Dental Assessment Form

Personal Data
Please Print Clearly – Please present completed form to your child's school after physician has completed

Child's Name: _____ Date of Birth: _____
(last) (first)

Address: _____
(street) (city) (state/zip)

Parent/Guardian Name: _____ **Phone**: _____

Yes	No	
☐	☐	Are you concerned about your child's health, weight, development or behavior?
☐	☐	Does anyone in your family have a condition that has affected their health, weight, development?
☐	☐	Has your child been seen by a provider for health, weight, development or behavior concerns?
☐	☐	Has your child had a dental exam by a dentist in the last 12 months?
☐	☐	Has your child had a well-child visit or check-up in the last 12 months?

Comments:
_____

Parental Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form and allow the Department of Health and Human Services to collect and analyze information from this form to better understand health needs of children in NC.

Parent/Guardian Signature: _____ **Date**: _____

Examination and Treatment Record
(List recommended services in order)

Tooth # or Letter	Description of work	Timeline	Date Services performed Mo/Day/Yr

Dental Needs (Circle all that apply)

A. Treatment (restoration, Pulp therapy, Extraction) **B**. Cleaning **C**. Fluoride **D**. Other **E**. No Problems

Child Oral Health Summary

All planned treatment (____ is, ____ is not) complete. If not complete, explain here as well as items circled.

a. Routine Recall visits
b. Dietary problems
c. Harmful oral habits
d. Special home emphasis on oral hygiene
e. Developmental problems
f. Needs fluoride supplement

I certify that I have completed the service(s) listed in this section and that the information on this form is accurate and completed to the best of my knowledge:

Providers Name: _____
Providers Signature: _____ Date: _____
Practice/Clinic Name: _____ Phone: _____
Provider Address: _____