WASHINGTON COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

2016–2017 DENTAL HEALTH FORM

1701 Colegate Drive
Marietta, Ohio 45750
Phone: 740-373-3781 fax: 740-373-1373

Child's Name_____ Date of Birth _____

1. IS THE CHILD NOW RECEIVING:
   Topical Fluoride Application? ____Yes ____ No ____ Unknown
   Fluoridated water? ____Yes ____ No ____ Unknown
   Fluoride Supplement diet? ____Yes ____ No ____ Unknown
   (___tablets, ___liquid)
   If "Yes", include length of time receiving fluoride

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOW ABOUT?

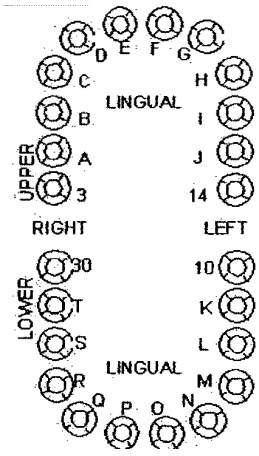
3. CHILD (____HAS, ____ HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist Name _____ Date Last Visit _____

4. CHILD (____IS, ____ IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's Name
   _____

5. CHILD (____ IS, ____ IS NOT) RECEIVING MEDICATION.
   Type_____

6. PRIORITY GROUP
   ____ Needs Attention Immediately
   ____ Needs Attention Soon
   ____ Needs Routine Care

7. ORAL CONDITIONS BEFORE TREATMENT:



Indicate restorations you perform in Item 8.

Missing X

Decayed ●

Filled ●

8. EXAMINATION AND TREATMENT RECORD
   (List recommended services in order).

Tooth # or Letter	Surfaces	Description of Work	Date Service Performed Month	Day	Year

9. DENTAL NEEDS (Check one or more and return after visit.)
   ___ TREATMENT (restoration, pulp therapy, extraction) ___ CLEANING ___ FLUORIDE
   ___ OTHER ___ NO PROBLEMS

10. CHILD ORAL HEALTH SUMMARY
    All planned treatment (___is, ___ is not) complete. If not, explain here, as well as items checked.
    _____
    _____

    ___ Routine recall visits ___ Dietary problem(s) ___ Harmful oral habits
    ___ Special home emphasis, oral hygiene ___ Developmental problem(s) ___ Needs fluoride supplement

Dentist's Signature **Dentist's Name (Please Print)** **Date** **Phone**

Form must have Dentist's signature and date.