



District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

| | | | | | | | |
|---|--|---|--|---------------------------------|--|--|-----------|
| Child's Last Name | | Child's First & Middle Name | | Date of Birth | Gender: <input type="checkbox"/> M <input type="checkbox"/> F | School or Child Care facility: | |
| Parent/Guardian Name | | Telephone1: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work | | Home Address: | | | Ward |
| Emergency Contact: | | Telephone2: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work | | City/State (if other than D.C.) | | | Zip code: |
| Race/Ethnicity: <input type="checkbox"/> White Non Hispanic <input type="checkbox"/> Black Non Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other _____ | | | | | | | |
| Primary Care Provider (Medical): | | | | Dentist/Dental Provider: | | <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> None <input type="checkbox"/> Other _____ | |

Part 2. Child's Clinical Examination (to be completed by the Dental Provider)
(Please use key to document all findings on line next to each tooth)

Date of Exam _____

- | | | | |
|----------|----------|---------|---------|
| Tooth # | Tooth # | Tooth # | Tooth # |
| 1 _____ | 17 _____ | A _____ | K _____ |
| 2 _____ | 18 _____ | B _____ | L _____ |
| 3 _____ | 19 _____ | C _____ | M _____ |
| 4 _____ | 20 _____ | D _____ | N _____ |
| 5 _____ | 21 _____ | E _____ | O _____ |
| 6 _____ | 22 _____ | F _____ | P _____ |
| 7 _____ | 23 _____ | G _____ | Q _____ |
| 8 _____ | 24 _____ | H _____ | R _____ |
| 9 _____ | 25 _____ | I _____ | S _____ |
| 10 _____ | 26 _____ | J _____ | T _____ |
| 11 _____ | 27 _____ | | |
| 12 _____ | 28 _____ | | |
| 13 _____ | 29 _____ | | |
| 14 _____ | 30 _____ | | |
| 15 _____ | 31 _____ | | |
| 16 _____ | 32 _____ | | |

Key (Check Appropriate)

| | |
|----------------------------------|----------------------------|
| S - Sealants | X - Missing teeth |
| ● Restoration | Non-restorable/ Extraction |
| 1D-One surface decay | UE- Unerupted Tooth |
| 2D-Two surface decay | |
| 3D-Three surface decay | |
| 4D-More than three surface decay | |

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

| | Findings | Comments |
|--|----------|----------|
| 1. Gingival Inflammation | Y N | |
| 2. Plaque and/or Calculus | Y N | |
| 3. Abnormal Gingival Attachments | Y N | |
| 4. Malocclusion | Y N | |
| 5. Other (e.g. cleft lip/palate) | | |
| Preventive services completed <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Part 4. Final Evaluation/Required Dental Provider Signatures

| | | |
|--|------------|------|
| This child has been appropriately examined. Treatment <input type="checkbox"/> is complete. <input type="checkbox"/> is incomplete. Referred to | | |
| DDS/DMD Signature | Print Name | Date |
| Address | | |
| Phone | Fax | |

Part 5. Required Parent/Guardian Signatures

| | |
|--|------|
| Parent or Guardian Release of Health Information. I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health | |
| PRINT NAME of parent or guardian | |
| SIGNATURE of parent or guardian | Date |

Instructions For Completion of Oral Health Assessment Form: District of Columbia Child Health Certificate

This Form replaces the Dental Appraisal Form used for entry into DC Schools, all Head Start programs, Childcare providers, camps, after school programs, sports or athletic participation, or any other District of Columbia activity requiring a physical examination. The form was developed by the DC Department of Health and follows the American Academy of Pediatric Dentistry (AAPD) Guidelines on Mandatory School-Entrance Oral Health Examinations. AAPD recommends that a child be given an oral health exam within 6 months of eruption of the child's first tooth and no later than his or her first birthday. The DC Department of Health recommends that all children 3 years of age and older have an oral health examination performed by a licensed dentist and have the DC Oral Health Assessment Form completed. This form is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers, and the Family Education Rights and Privacy Act (FERPA) for the DC schools and other providers.

General Instructions: Please use black ball point pen when completing this form.

Part 1: Child's Personal Information

Please complete all sections including child's race or ethnicity. Please indicate the ward of your home address. List primary care provider, dental provider, and type of dental insurance coverage. If child has no dental provider and is uninsured, then please write "None" in each box. This form will not be complete without **Parent or Guardian** signature in Part 5.

Part 2: Child's Clinical Examination: Dental Provider: Form must be fully completed. The Universal Tooth Numbering System is used.

Please use key to document all findings for each tooth. An 'X' signifies a missing tooth (teeth) with no replacement; **U**: non-restorable/extraction; **UE**: unerupted tooth; **S**: Sealants; **R**: Restoration; **1D**: one surface decay; **2D**: two surface decay; **3D**: three surface decay; **4D**: more than three surface decay

- The Key should be used to designate status for each tooth at time of examination on the Oral Health Assessment Form.
- If a portion of an existing restoration is defective or has recurrent decay, but part of the restoration is intact, the tooth should be classified as a decayed tooth. If one surface has decay, then mark as **1D**; if two surface has decay then mark as **2D**.
- Key **UE**: unerupted, does not apply to a missing primary tooth when a permanent tooth is in a normal eruption pattern.

Part 3: Clinical Findings and Recommendations

- Circle **Yes** or **No** in Findings Column
- For **Yes**, please explain in the Comments Section.
- 1- Advance periodontal conditions (pockets etc., will be noted under gingival inflammation).
- 1- Gingival inflammation adjacent to an erupting tooth is **NOT** noted.
- 1- Inflammation adjacent to orthodontically banded teeth or a dental appliance – whether fixed or removable is noted.
- 2- Indicate if there is sub and/or supra gingival plaque and or calculus and areas where present.
- 3- All gingival tissues must be free of inflammation e.g. gingiva is pale pink in color and firm in texture for a finding of 'NO' to be recorded.
- 3- Frenum attachments labial, sublingual, etc., will be noted under the Abnormal Gingival Attachment Indicator Code if they are the cause of a specific problem- e.g., spacing of central incisors, speech impediment, etc.
- 4- Status of orthodontic condition should be noted under Malocclusion. Classification of occlusion is: Class I, Class II, Class III, an overbite, over jet, cross-bite or end to end.
- 5- Other is to be used, together with comments, for conditions such as cleft lip/palate.
- Indicate whether oral health preventive services such as prophylaxis, sealant and or fluoride treatment have been administered.

Part 4. Final Evaluation/Required Dental Provider Signature: Indicate whether the child has been appropriately examined and if treatment is complete. If treatment is incomplete refer patient for follow up care. Dentist must **sign, date, and provide required information.**

Part 5 Required Signatures. This Form Will Not Be Complete Without Parent or Guardian Signature & Date

The parent or guardian must print, sign, and date this part. By signing this section the parent or guardian gives permission to the dentist or facility to share the oral health information on this form with the child's school, childcare, camp, Department of Health, or the entity requesting this document. All information will be kept confidential.