

**Oral Health Assessment Form**

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

**Instructions**

- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

**Part 1: Student Information (To be completed by parent/guardian)**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

School or Child Care Facility Name National Child Research Center

Date of Birth (MMDDYYYY)

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Home Zip Code

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School Grade	Day-care	PreK3	PreK4	K	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part 2: Student's Oral Health Status (To be completed by the dental provider)**

	Yes	No		
Q1 Does the patient have at least one tooth with <b>apparent cavitation</b> (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	<input type="checkbox"/>	<input type="checkbox"/>		
Q2 Does the patient have at least one <b>treated carious tooth</b> ? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	<input type="checkbox"/>	<input type="checkbox"/>		
Q3 Does the patient have at least one permanent molar tooth with a <b>partially or fully retained sealant</b> ?	<input type="checkbox"/>	<input type="checkbox"/>		
Q4 Does the patient have untreated caries or other oral health problems requiring <b>care before his/her routine check-up? (Early care need)</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Q5 Does the patient have <b>pain, abscess, or swelling? (Urgent care need)</b>	<input type="checkbox"/>	<input type="checkbox"/>		
Q6 How many <b>primary teeth</b> in the patient's mouth are affected by caries that are either <b>untreated or treated with fillings/crowns</b> ?	Total Number			
	<input type="text"/>			
Q7 How many <b>permanent teeth</b> in the patient's mouth are affected by caries that are either <b>untreated, treated with fillings/crowns, or extracted due to caries</b> ?	Total Number			
	<input type="text"/>			
Q8 What type of dental insurance does the patient have?	Medicaid	Private Insurance	Other	None
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dental Provider Name _____	Dental Office Stamp
Dental Provider Signature _____	
Dental Examination Date _____	

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care centers. This form is approved by the DC Health and 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 Right and Privacy Act (FERPA) for the DC Schools and other providers.