ORAL HEALTH ASSESSMENT

7420 SW Hunziker St, Suite F
Tigard, OR 97223

Child's Name ______________________

Date of Birth ______________ **Zip Code** ______________

Site ______________ **Classroom** ______________

OHP # ______________________

DCO ______________________

Private______________________

None ______________________

No Treatment Needed (Child is up to date with care) ☐ **Date of assessment** ______________

Treatment Indicated ☐ **Approximate number of appointments needed**________________________

Treatment in Progress ☐ **Next scheduled appointment**________________________

Did child receive preventive care?

☐ Fluoride varnish ☐ Cleaning ☐ Other _____________________________

ASTDD/Basic Screening Survey indicators:

Child has cavities: ☐ Yes ☐ No

Child has treated decay (fillings) ☐ Yes ☐ No

Child has ECC (current or past decay in upper anterior teeth): ☐Yes ☐No

Treatment Urgency:

☐ 0 No obvious problems
☐ 1 Early Dental Care needed
☐ 2 Urgent Care needed (pain/infection)

ASTDD/Basic Screening Survey indicators: **Pregnant Women**

Pregnant woman has cavities: ☐ Yes ☐ No

Pregnant woman has treated decay (fillings) ☐ Yes ☐ No

Pregnant woman has gum disease: ☐Yes ☐No

Treatment Urgency:

☐ 0 No obvious problems
☐ 1 Early Dental Care needed
☐ 2 Urgent Care needed (pain/infection)

Notes/Comments:

Treatment ☐ complete ☐ incomplete

Name of Dentist/Clinic ____ **Phone:** ____________________

Signature of Dental Provider: ____ **Date:** ______/______/______