CONFIDENTIAL FORM- SIDE ONE

Please review instruction on side two prior to completing form

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:* ☐M ☐F	*School or Child Care facility:*
Parent/Guardian Name	*Telephone1: ☐Home ☐Cell ☐Work*	*Home Address:*		*Ward*
Emergency Contact:	*Telephone2: ☐Home ☐Cell ☐Work*	*City/State (if other than D.C.)*		*Zip code:*
Race/Ethnicity: ☐White Non Hispanic ☐Black Non Hispanic ☐Hispanic ☐Asian or Pacific Islander ☐Other_____				
Primary Care Provider (Medical):	*Dentist/Dental Provider:*	*☐Medicaid ☐Private Insurance ☐None ☐Other _____*		

Part 2. Child's Clinical Examination (to be completed by the Dental Provider)

Date of Exam _____

(Please use key to document all findings on line next to each tooth)

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

● Restoration

1D-One surface decay

2D-Two surface decay

3D-Three surface decay

4D-More than three surface decay

X - Missing teeth

| Non-restorable/ Extraction

UE- Unerupted Tooth

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 ☐ Yes ☐ No		

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. **Treatment** ☐ is complete. ☐ 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; non-restorable/extraction; **UE:** unerupted tooth; **S:** Sealants; Restoration; **1D:** one surface decay; **2D:** two surface decay; **3D:** three surface decay; **4D:** more then 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 s**ign, 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.