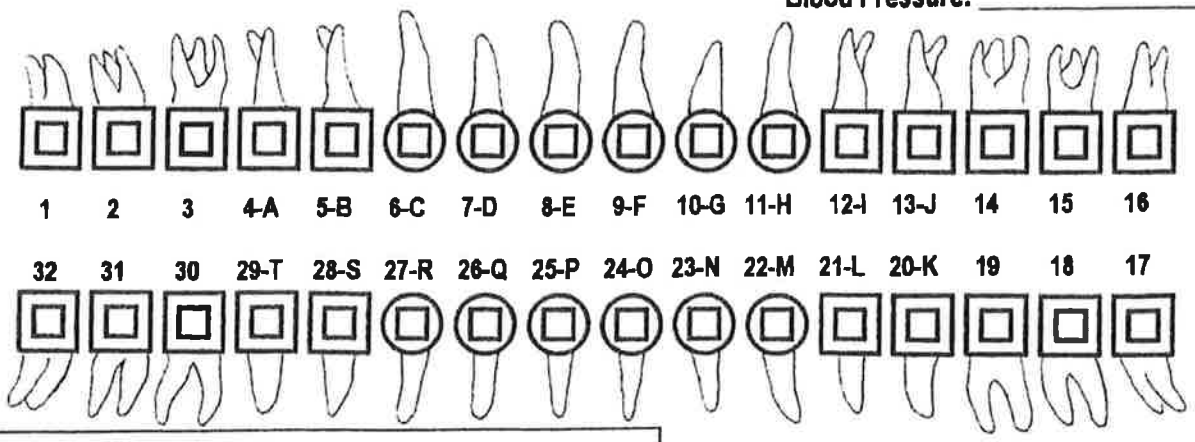
DENTAL SCREENING FORM

Medical Alert

☐ See Health History

Patient Name: _____ **Patient Number:** _____

Blood Pressure: _____



Soft Tissue ☐ WNL ☐ See Progress Notes

TMJ ☐ WNL ☐ See Progress Notes

3rd Molars ☐ WNL ☐ Impacted Tooth # ☐ 1 ☐ 16 ☐ 17 ☐ 32

Enamel Defects: Teeth # ___ ___ ___ ___ ___ ___

Orthodontics ☐ I ☐ II Div. I ☐ II Div. II ☐ III

CPITN SCORES

3	8	14
30	24	19

Date: _____

3	8	14
30	24	19

Date: _____

Periodontal Diagnosis: _____

Periodontal Tx Needed: _____

Recall _____ **Months**

Home Care	Excellent	Fair	Poor
Stain	L	M	H
Plaque	L	M	H
Calculus	L	M	H

Prevention Assessment

Water Fluoride _____ ppm

	Yes	No
On School FMR	___	___
Use Fl Toothpaste	___	___

☐ Lives in area with water fluoridation.

☐ Informed about supplements and desires a prescription.

☐ Informed about supplements, but rejected a prescription.

☐ Beyond fluoride supplement age.

☐ Patient is currently taking fluoride supplement.

Recommendations

	Yes	No
APF Topical	___	___
Fluoride Tabs/Drops	___	___
Sealants	___	___
OHI	___	___
BBTD Counseling	___	___
Tobacco Counseling	___	___
Other Education	___	___

REFERRAL

To: Date: Reason:

_____

_____

_____

_____

Treatment Plan

Date	Tooth	Surface	Service Provided

Provider's Signature: **Exam Date:**

PATIENT INFORMATION: CHART #: _____

Last Name:_____ First Name:_____ Middle Initial:____ Sex: M F

Mailing Address:_____ City:_____ State:_____ ZIP:_____

Home Address:_____ City:_____ State:_____ ZIP:_____

Social Security #:_____ Birthdate:_____ Birthplace:_____

Telephone: Home #:_____ Work #:_____ Cell/Message #:_____

Religion:_____ If Non-Indian, Ethnic Background:_____

If Indian, please indicate Tribal Affiliation:_____

EMPLOYMENT INFORMATION:

Employer Name:_____

Address:_____ City:_____ State:_____ ZIP:_____

Monthly Gross Income:_____ Family Size (# of people in household):_____

EMERGENCY CONTACT:

Name:_____ Relationship:_____ Phone #:_____

Address:_____ City:_____ State:_____ ZIP:_____

PERSON RESPONSIBLE FOR BILL:

Name:_____ Relationship to Patient:_____

Address:_____ City:_____ State:_____ ZIP:_____

Do you have private insurance? ☐ Yes ☐ No If Yes, Name of Insured:_____

Name of Insurance Company:_____ Group ID #:_____ Subscriber's ID #:_____

Do you have ***other*** private insurance? ☐ Yes ☐ No If Yes, Name of Insured:_____

Address:_____ City:_____ State:_____ ZIP:_____

Do you have state Medi-Cal? ☐ Yes ☐ No If Yes, Name of Insured:_____

With my signature below, I hereby authorize the release of any information, including diagnosis of a medical or dental condition for the sole purpose of submitting claims to third-party billing insurance carriers and the above statements are true and accurate to the best of my knowledge. I understand that if all insurance information is not completed and correct that I will be responsible for the cost of all services rendered.

Patient or Guardian Signature:_____ Date:_____

NATURAL OR ADOPTED PARENTS:

Father's Name: First Name:_____ Last Name:_____

Father's Birthplace (if known): City & State:_____

Mother's Name: First Name:_____ Last Name (Maiden):_____

Mother's Birthplace (if known): City & State:_____

INFORMATION FOR MINORS & CHILDREN ONLY:

With my signature below, I hereby grant permission to the listed & named adults below who, in my absence, may accompany and make any and/or all decisions regarding dental treatment needed for my minor/child.

Parent or Guardian Signature:_____ Date:_____

NAMED ADULT:_____ Relationship to Child:_____

NAMED ADULT:_____ Relationship to Child:_____

CONSENT FOR DENTAL TREATMENT:

I hereby give permission to Toiyabe Indian Health Project, Inc., Dental Department, to perform dental work for the repair and maintenance of dental and oral health. The dental personnel have my permission to administer local anesthetics and other medications as deemed necessary to treat my dental condition(s) properly.

Patient or Guardian Signature:_____ Date:_____

Review Signature:_____ Date:_____

Review Signature:_____ Date:_____