

# DENTAL SCREENING FORM

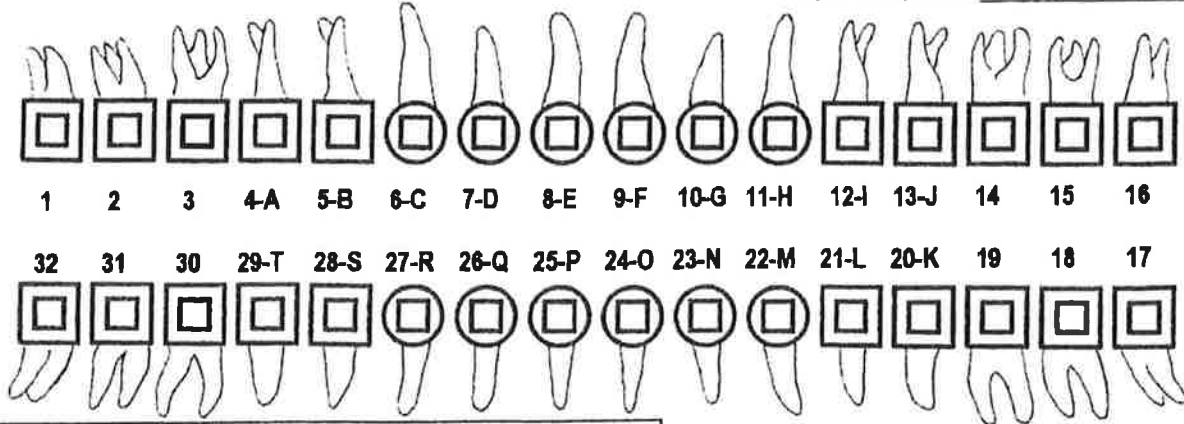
## Medical Alert

See Health History

Patient Name: \_\_\_\_\_

Patient Number: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_



Soft Tissue  WNL  See Progress Notes  
 TMJ  WNL  See Progress Notes  
 3<sup>rd</sup> 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: \_\_\_\_\_ Date: \_\_\_\_\_

Periodontal Diagnosis: \_\_\_\_\_

Periodontal Tx Needed: \_\_\_\_\_

Recall _____ Months	Excellent	Fair	Poor
Home Care	L	M	H
Stain	L	M	H
Plaque	L	M	H
Calculus	L	M	H

**Prevention Assessment**  
 Water Fluoride \_\_\_\_\_ ppm      Yes      No  
 On School FMR \_\_\_\_\_  
 Use FI 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	_____	_____

### Treatment Plan

Date	Tooth	Surface	Service Provided

**REFERRAL**  
 To: \_\_\_\_\_ Date: \_\_\_\_\_ Reason: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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: \_\_\_\_\_