



CHILDREN'S ORAL HEALTH SCREENING FORM

Name _____

Gender 1 = M 2 = F

Assent Given

_____ Date of Birth

<p>1. First Permanent Molars</p> <p>A. # Carious <input type="checkbox"/></p> <p>B. # with Sealants <input type="checkbox"/></p> <p>C. # Filled <input type="checkbox"/></p> <p>D. # Missing <input type="checkbox"/></p>	<p>2. Untreated Cavities <input type="checkbox"/> 0= No untreated cavities 1= Untreated cavities</p>
<p>3. Caries Experience <input type="checkbox"/> 0= No caries experience 1= Caries experience</p>	<p>4. Sealants on Any Permanent Molars <input type="checkbox"/> 0= No sealants 1= Sealants present</p>
<p>5. # of Quadrants Needing Treatment <input type="checkbox"/></p>	<p>6. Treatment Urgency <input type="checkbox"/> 0= No obvious problem 1= Early dental care 2= Urgent care</p>
<p>7. Oral Injuries <input type="checkbox"/> 0= None 2= Org. Sports 1= Bike/Staves 3= Other</p>	<p>8. Gingival Signs <input type="checkbox"/> 0= No 1= Yes</p>
<p>9. Orthodontics <input type="checkbox"/> 0= No ortho appliances 1= Ortho. Appliances</p>	
<p>10. Overall Impression of Child's Teeth: <input type="checkbox"/> 1= Very Good 2= Good 3= Fair/Poor</p>	

Please comment on "Fair/Poor" _____

GENERAL COMMENTS: _____

Registered Dental Hygienist
 Dentist

_____ Dentist Date

