FLORIDA DEPARTMENT OF JUVENILE JUSTICE

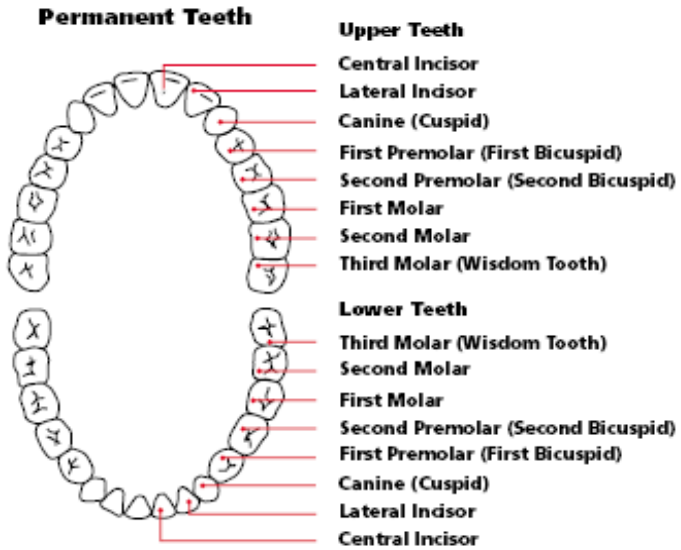
ORAL HEALTH ASSESSMENT

NAME OF YOUTH: _____

FACILITY NAME: _____

DDJID #: _____ **MEDICAID #:** _____
(AS APPLICABLE)

ORAL CONDITION ❑ **DATE OF EXAM:** _____



Key: ✕ Missing ⃠ Decayed ● Filled

Comments:

Number of times, per day, youth brushes teeth: _____

Flossing Frequency: ❑ Daily ❑ Weekly ❑ Occasionally ❑ Never

Gum Condition: ❑ Normal ❑ Swollen ❑ Bleeds Easily ❑ Infected

Dental Needs: ❑ Treatment ❑ Cleaning ❑ Oral Hygiene Instruction ❑ No Needs

❑ **Further Evaluation/Referral To:** ❑ **ARNP** ❑ **MD** ❑ **Dentist** **Date:** _____

Name

Address, City, State, Zip

Area Code/Phone Number

Name (Person Completing Form) **Title** **Date**