

ORAL HEALTH ASSESSMENT

NAME OF YOUTH:					
FACILITY NAME:					
DDJID #: MEDICAID #:(AS APPLICABLE)					
ORAL CONDITION			DATE OF EXAM:		
Permanent Teeth	Second Premo First Molar Second Molar Third Molar (W Lower Teeth Third Molar (W Second Molar First Molar Second Premo	(First Bicuspid) (First Bicuspid) (Iar (Second Bicuspid) (Isdom Tooth) (Isdom Tooth) (Isdom Tooth) (Isr (Second Bicuspid) (First Bicuspid)	Com	ments:	
Key: X Missing	○ Decayed	● Filled			
Number of times, per da	_		По		D.N.
Flossing Frequency:	☐ Named	_	_	asionally	☐ Never
Gum Condition: Dental Needs:	☑ Normal☑ Treatment	☐ Swollen☐ Cleaning	_	eds Easily I Hygiene Instruction	☐ No Needs
Demai Neeus.	- Heatment	- Cleaning	■ Ola	Triygierie iristruction	INO Needs
☐ Further Evaluation	n/Referral To:		ID 🗆	Dentist Date:	
Name					
Address, City, State, Z	ip				
Area Code/Phone Num					
Name (Person Comple	ting Form)			Title	Date