UNIVERSAL PRE-KINDERGARTEN DENTAL EXAMINATION FORM

Child's Name: _____

Address: _____ City: _____ Zip code: _____

Sex: _____ Date of Birth: _____ UPK Site: _____

1. IS THE CHILD NOW RECEIVING: If "yes" include length of time receiving fluoride
   Topical Fluoride Application? No ___ Unknown ___ Yes ___
   Fluoridated water? No ___ Unknown ___ Yes ___
   Fluoride Supplement diet? No ___ Unknown ___ Yes ___
   (Tablets ___, Liquid ___)

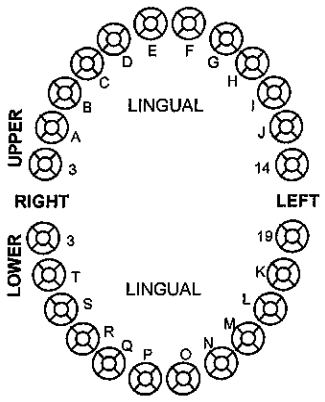
2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAT THE PARENT KNOWS ABOUT?

3. CHILD ___HAS, ___HAS NOT PREVIOUSLY SEEN A DENTIST.
   Dentist's name _____
4. CHILD ___IS, ___IS NOT UNDER A PHYSICIAN'S CARE.
   Physician's name _____
5. CHILD ___HAS, ___HAS NOT BEN RECEIVING MEDICATION.
   Type _____
6. CHILD IS REPORTED TO HAVE (Give details or attach health history)

	YES	NO		YES	NO
Allergies	___	___	Liver Disease	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Disease	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___	_____		
Heart/Vascular Dis.	___	___	_____		

7. SOURCE OF REIMBURSEMENT FOR SERVICES
   ___ EPSDT/Medicaid
   ___ Federal, State or Local Agency
   _____
   ___ Head Start
   ___ In-kind Provider
   _____
   ___ Parents/Guardians
   ___ Other (3rd Party)
8. PRIORITY GROUP
   ___A. Needs attention immediately
   ___B. Needs Attention Soon
   ___C. Needs Routine Care

9. ORAL CONDITIONS BEFORE TREATMENT:
   (Indicate restorations performed in Item 10)
   Red= Decay Blue= Filling X= Missing



10. EXAMINATION AND TREATMENT RECORD
    (List recommended services in order)

Tooth # or Latter	Surface	Description of Work	Treatment Approved	Date Service Performed MO. DAY YR.	A.D.A. Procedure Number

11. DENTAL NEEDS (Check all that apply and return to UPK site after first visit).
    ___ Treatment (restoration, pulp therapy, extraction) ___ Cleaning ___ Fluoride
    ___ Other: _____ ___ No Problems
    Approximate number of visits: ____

12. DENTAL HEALTH SUMMARY (complete and return to UPK site after final visit)
    All planned treatment ____is, ____is not complete. If not complete, explain:
    _____
    ___ Routine recall visits ___ Dietary problem(s) ___ Harmful oral habits ___Special home emphasis, oral hygiene
    ___ Developmental concern ___Needs fluoride supplement
    I certify that I have completed the service(s) listed in in Item 10. _____ _____
    Signature Date