Dental Assessment Form

Parents please complete the top portion and return completed form to your child's school or Smart Start Rowan after dentist has **completed, signed & dated** the bottom section.

Child's Name: _____Date of Birth: _____
(first) (last)

Address: _____
(street) (city) (state/zip)

Parent/Guardian Name: _____ **Phone**: _____

YES	NO	
☐	☐	Has your child had a dental exam by a dentist in the last 12 months?
☐	☐	Do you have any concerns about your child's dental health? (If so please list in comments below.)

Comments:

_____

Parental Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form and allow the Department of Health and Human Services to collect and analyze information from this form to better understand health needs of children in NC.

Parent/Guardian Signature: _____**Date**: _____

Dental Exam Findings

☐ No cavities/decay present or no obvious problems ☐ Cavities/decay present or dental care needed (see below)

Dental Needs (Circle all that apply)

A. Treatment needed **B**. Cleaning **C**. Fluoride **D**. Routine Recall visits needed
E. Special home emphasis on oral hygiene needed **F.** Dietary problems **G**. Developmental problems
H. Harmful oral habits **I**. Other _____

Comments: _____
_____
_____

I certify that I have provided a dental exam and that the information on this form is accurate and completed to the best of my knowledge:

Practice/Clinic Name: _____ Phone: _____

Provider Address: _____

Providers Signature: _____ **Date:** _____

<u>Dentist signature/date required</u> – Dental Stamp cannot be accepted!