UMCHS - EHS DENTAL SCREENING RECORD

Child's Name______________________________ DOB:______________ Sex:______________

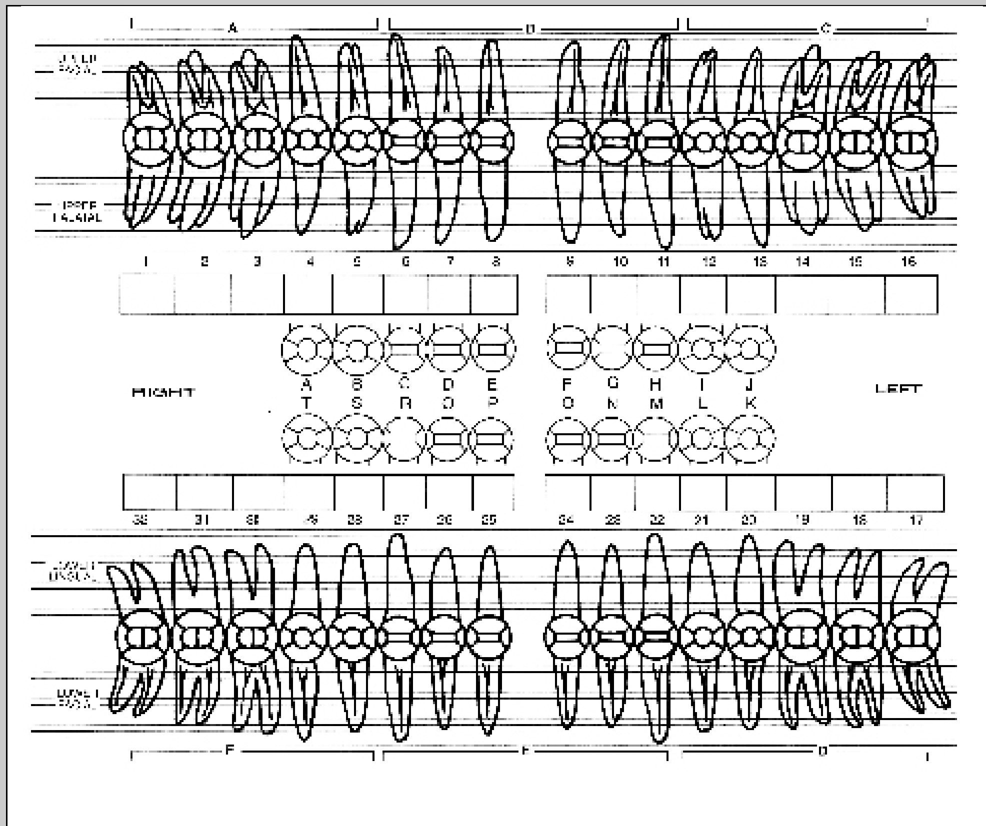
OHP/Medicaid Number:______________________________ HS/EHS Center:______________________

Insurance Provider:______________________ Group:______________ Plan:______________

Parent/Guardian:______________________________ Phone:______________________

Address (Street & City):______________________________ ZIP Code:______________

HISTORY	ALLERGIES: MEDICATIONS:



TOOTH	OBSERVATIONS	TOOTH	OBSERVATIONS

SOCIAL/EMOTIONAL & BEHAVIORAL OBSERVATIONS:

PARENT/SCREENER
(Check "✓" All Boxes that Apply.)

☐ Parent Facilitated Screen
☐ Staff Facilitated Screen
☐ Child Did Not Tolerate Screening Well

HEALTH EDUCATION

☐ Parent Viewed "Lift the Lip" Video
☐ Parent Reviewed Information on Oral Hygiene Instruction
☐ Parent Reviewed Information on Topical and Systemic Fluoride

SCREENING RESULTS

☐ Screening Complete, No Concerns
☐ Screening Complete, Concerns Noted Referred to Dental Provider for For Exam & Evaluation

Parent Signature:______________________________ Screen Date:______________________

Staff Signature: ______________________________

PLEASE RETURN EXAM RECORD TO UMCHS AT 110 NE 4TH STREET, HERMISTON, OR 97838
1-800-559-5878 – (541) 564-6878 – (541) 564-6879 FAX