



Oral Health Exam Record

Dentist Name: _____ Phone: _____

Dental Office Name & Address: _____

Type of Visit: Initial 6-month Routine Visit Restorative Specialist Follow-up Other _____

Date of Last Dental Visit: _____ Reason for last visit: _____

Patient Information (Required--To be completed by Full Case Management Agency)

Patient's Name: _____ DOB: _____ Age: _____ Sex: M F

Agency: CFCE Charlee His House Wesley House CHS FRC Other _____

Case Manager Name: _____

Please list any known medical conditions: _____

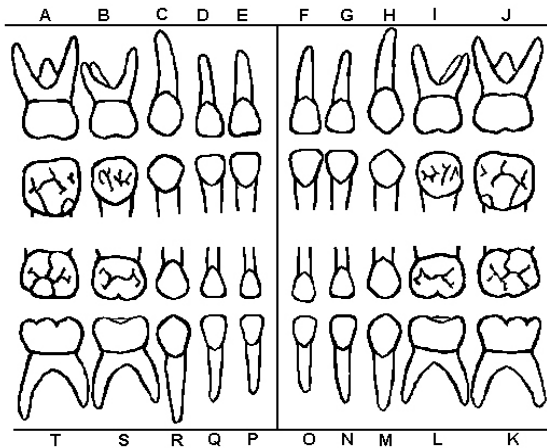
Please list all current medications: _____

Dental Issues Noted (To be completed by Dentist)

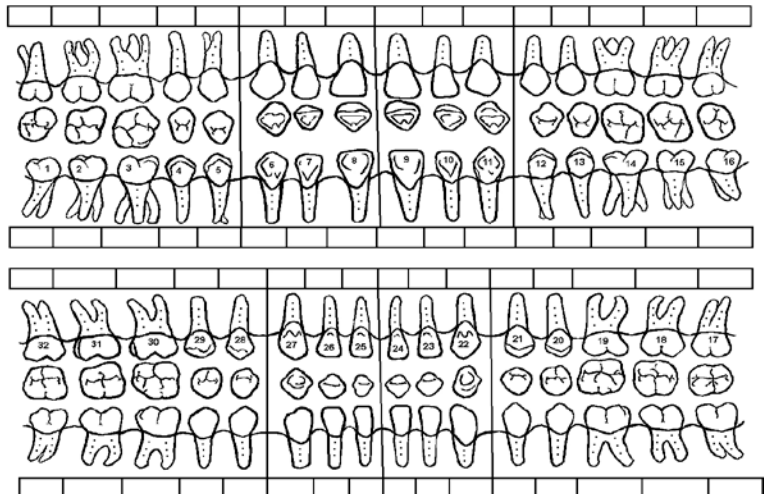
Please describe any issues noted and mark problem areas on appropriate chart(s) below:

Check here if no dental issues/ problems are found

Primary Dentition Chart



Permanent Dentition Chart



Services Completed (Check all that apply): X-Rays Fluoride Prophylaxis Floss Ultrasonic Scaling Polish OHI

Debridement Sealants, Tooth#: _____ Fillings, Tooth#: _____ Crown Tooth#: _____

Extraction, Tooth#: _____ Root Canal Tooth#: _____ Other _____

Patient Status (Check all that apply): Normal Exam Treatment Recommended Treatment in Progress Referral Submitted

Pre-Auth Submitted All Treatment Completed / Notes: _____

Follow Up (Check all that apply): 6-Month Recall Restorative Specialist Urgent Care Needed Other _____

Referrals (Check all that apply): Oral Surgery Orthodontics Pediatric Dentistry Endodontics Prosthodontics

Periodontics Sedation Dentistry Other _____

Next Scheduled Appointment: _____

Reason for Appointment: _____

Dentist Signature: _____

Date of Service: _____

