Dental Screening Record

Name:_____ **Date:** _____

Age: ___0-2 ___2-5 ____5-11 ____ 11-17 ____ 18-65 ____ 65+

Ethnicity: __ Hispanic/Latino __ Not Hispanic/Latino **Migrant /Farmworker:** yes / no

- *I acknowledge this screening does not take the place of a dental exam, which is recommended every 6 months with a dental professional and x-rays, for the prevention of cavities and oral disease.* _____ (Initial)
- *By participating in this free screening I release the HDA of any liability.* _____ (Initial)

Your dental screening indicates:

___ No obvious dental problems

___ Oral Cancer Screening

___ Dental Caries

___ Gum Disease

___ Need for urgent care because of **(**Pain/Infection/Pathology etc.) _____

Dental Services Provided: (check all that apply)

___ Screening ___Education ___ Fluoride ___ Sealants ___ Dental Treatment

Dentist/Health Professional: _____ **License #**_____

TOP PORTION FOR HDA/BOTTOM FOR PATIENT

Thank you for participating in our dental screening today.

This screening does not take the place of a dental exam, which is recommended every 6 months with a dental professional and x-rays, for the prevention of cavities and oral disease.

Patient Name: _____ Date _____

Dental Services Provided: (check all that apply)

___ Screening ___Education ___ Fluoride ___ Sealants ___Dental Treatment

The following explains what we recommend based on today's findings.

___ No obvious cavities seen, complete exam with x-rays needed.

___ Inflammation of the gums is present & a cleaning is needed to prevent further infection.

___ Cavities present, we recommend you see a dentist soon for fillings.

___ Infection/abscess present, see a dentist immediately.

___ Visit the dentist about other conditions _____

Dentist/Health Professional: _____ **License #**_____