REPORT OF DENTAL EXAMINATION FOR CHILD IN FOSTER CARE

CASE WORKER NAME

CASE NAME

CASE WORKER CODE PHONE NO.

PATIENT'S NAME (LAST) (FIRST) (MI)

MEDI-CAL I.D. NUMBER

RESPONSIBLE PERSON'S NAME (LAST) (FIRST) PHONE NO.

RESPONSIBLE PERSON'S ADDRESS (STREET) (CITY) (ZIP)

PATIENT'S BIRTHDATE MO DAY YR	SEX F M	DATE OF EXAM MO DAY YR

Lips & Buccal Mucosa

Tongue & Floor of Mouth

Salivary Glands

Lymph Nodes

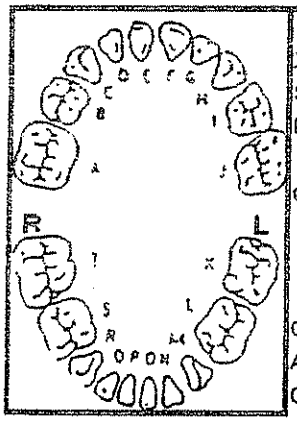
Palate

Propharynx

TMJ

DATE	TOOTH	FINDINGS\SERVICE

Referrals Ortho Peric Pedo Other



X-RAYSFM_____ B-W____ AREA_____

STUDY MODELS _____ AGE_____

PHOTOGRAPHS - BEFORE _____

AFTER _____

ORAL FINDINGS

HYGIENE 1 2 3 4_____

DEPOSITS 1 2 3 4_____

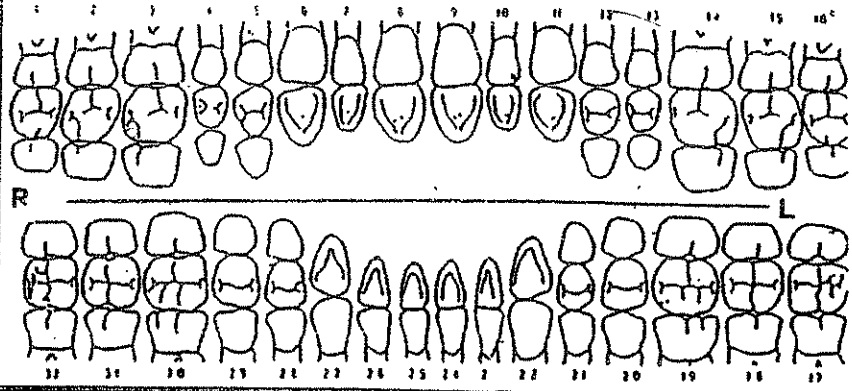
PERIODONT 1 2 3 4_____

OCCLUSION _____

ABNORMALITIES _____

CONDITION OF TEETH _____

NOTES



(NAME/ADDRESS/PHONE NO. OF EXAMINING DENTIST)

(PLEASE PRINT OR TYPE)

Return completed exam in envelope provided or send to:

SIGNATURE OF DENTIST DATE

(CS 344 7/00)