SACRAMENTO COUNTY

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			SEX		DATE OF EXAM		
MO	DAY	YR	F	M	MO	DAY	YR

Lips & Buccal Mucosa

Tongue & Floor of Mouth

Salivary Glands

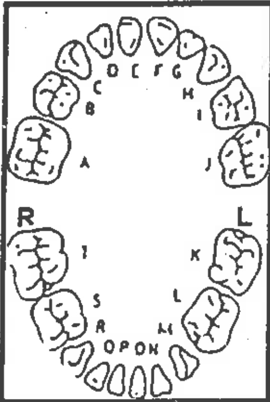
Lymph Nodes

Palate

Propharynx

TMJ

Referrals Ortho Perio 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________

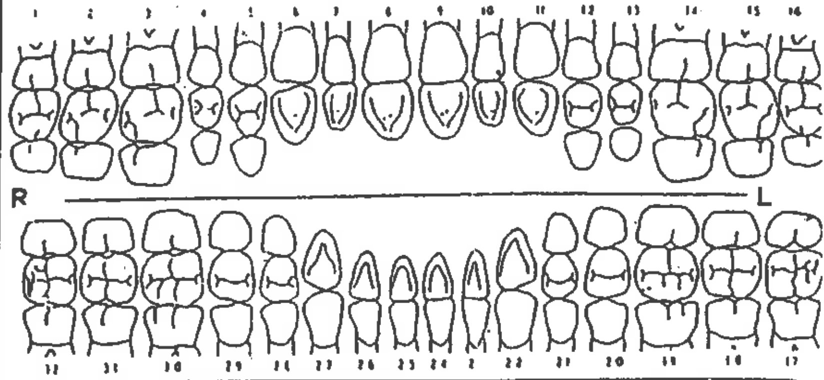
PERIODONT 1 2 3 4________

OCCLUSION __________

ABNORMALITIES __________

CONDITION OF TEETH __________

DATE	TOOTH	FINDINGS\SERVICE



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)

Distribution: White - Dr. Britton Yellow - Social Worker Pink - Foster Parent / Guardian / FFA