SHARE A SMILE in NJ

GKAS Referring Site:_____

DATE_____

Patient Name _____

DOB _____

Oral Hygiene Assessment:	_____ Good _____ Fair _____ Poor
BEHAVIOR: ++ + +- - --	

Check if completed

I. Oral Hygiene:

Prophylaxis _____ Comment _____

Fluoride Treatment _____ Comment _____

SDF _____ TEETH#s_____

Oral Hygiene Instruction ____ Comment_____

Sealants _____

II. Dental Examination:

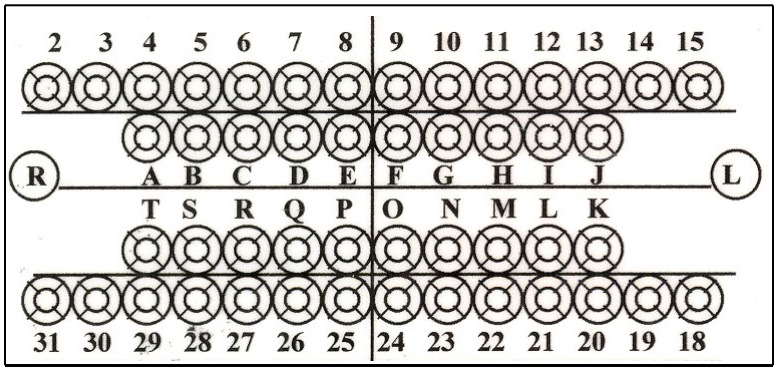
Examination _____ Comment _____

Radiographs _____ ____BW ____Occ ____PA ____ Pan

III. Charting:

Please use key to chart

Key
Decay- C
Missing- X
Restorative – O
Seal- S



IV. Needed Treatment

Comments _____ _____

Extraction: Teeth _____ _____

_____ _____+_____

Restorative: Teeth _____ _____

_____ _____

REFERRED BY:_____Printed name

_____ Signature

_____Phone number