



DENTAL ASSESSMENT FORM

LA SIERRA ACADEMY | 4900 GOLDEN AVENUE, RIVERSIDE, CA 92505 | P • 951-351-1445 | F • 951-689-3708

A CALIFORNIA LICENSED DENTAL PROFESSIONAL OPERATING WITHIN HIS SCOPE OF PRACTICE MUST PERFORM THE CHECK-UP AND FILL OUT SECTION 2 OF THIS FORM. IF YOUR CHILD HAD A DENTAL CHECK-UP IN THE 12 MONTHS BEFORE HE/SHE STARTED SCHOOL, ASK YOUR DENTIST TO FILL OUT SECTION 2. IF YOU ARE UNABLE TO GET A DENTAL CHECK-UP FOR YOUR CHILD, FILL OUT SECTION 3.

SECTION 1: CHILD'S INFORMATION (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name:	Child's race/ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____		

SECTION 2: ORAL HEALTH DATA COLLECTION (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date:	Caries Experience (Visible decay and/or fillings present) <input type="checkbox"/> Yes <input type="checkbox"/> No	Visible Decay Present: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment Urgency: <input type="checkbox"/> No obvious problem found <input type="checkbox"/> Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) <input type="checkbox"/> Urgent care needed (pain, infection, swelling or soft tissue lesions)
<i>Licensed Dental Professional Signature</i>		<i>CA License Number</i>	<i>Date</i>

SECTION 3: WAIVER OF ORAL HEALTH ASSESSMENT REQUIREMENT

To be filled out by parent or guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

- I am unable to find a dental office that will take my child's dental insurance plan.
 My child's dental insurance plan is:
 Medi-Cal/Denti-Cal Healthy Families Healthy Kids Other _____ None
- I cannot afford a dental check-up for my child.
 I do not want my child to receive a dental check-up.

Optional: other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement: _____
Signature of parent or guardian *Date*