CONFIDENTIAL FORM- SIDE ONE

Please review instructions on side two

District of Columbia Oral Health (Dental Provider) Assessment Form

Part 1. Child's Personal Information

Child's Last Name	Child's First & Middle Name	Date of Birth	Gender:	School or Child Care facility:
Giron	Matias Lekoudis	7/31/2020	☒ M ☐ F	CommuniKids

Parent/Guardian Name	Telephone1: ☐ Home ☒ Cell ☐ Work	Home Address:	Ward
Olivier Giron	571-214-8163	3546 W PL NW	3

Emergency Contact:	Telephone2: ☐ Home ☒ Cell ☐ Work	City/State (if other than D.C.)	Zip code:
Marilena Lekoudis, Olivier Giron	703-969-8356, 571-214-8163		20007

Race/Ethnicity: ☐ White Non Hispanic ☐ Black Non Hispanic ☐ Hispanic ☐ Asian or Pacific Islander ☒ Other Greek/Latino

Primary Care Provider (Medical):	Dentist/Dental Provider:	☐ Medicaid ☒ Private Insurance ☐ None
Dr. Felker, 202-444-8168	Dr. Reardon, 703-579-0367	☐ Other

Part 2. Child's Clinical Examination (to be completed by the Dental Provider)

Date of Exam 12/2/2022

(Please use key to document all findings on line next to each tooth)

Tooth #	Tooth #	Tooth #	Tooth #
1	17	A	K
2	18	B	L
3	19	C	M
4	20	D	N
5	21	E	O
6	22	F	P
7	23	G	Q
8	24	H	R
9	25	I	S
10	26	J	T
11	27		
12	28		
13	29		
14	30		
15	31		
16	32		

Key (Check Appropriate)

S - Sealants
X - Missing teeth
● Restoration
| Non-restorable/ Extraction
1D-One surface decay
UE- Unerupted Tooth
2D-Two surface decay
3D-Three surface decay
4D-More than three surface decay

Part 3. Clinical Findings and Recommendations (Please indicate in Finding column)

	Findings	Comments
1. Gingival Inflammation	Y (N)	
2. Plaque and/or Calculus	Y (N)	
3. Abnormal Gingival Attachments	Y (N)	
4. Malocclusion	Y (N)	
5. Other (e.g. cleft lip/palate)		
Preventive services completed ☒ Yes ☐ No	Exam Only	

Part 4. Final Evaluation/Required Dental Provider Signatures

This child has been appropriately examined. **Treatment** ☐ is complete. ☐ is incomplete. Referred to

DDS/DMD Signature [signature] Print Name Christine Reardon Date 12/2/22

Address Christine Reardon, D.M.D. 3565 Langston Blvd Ste. A Arlington, VA 22207

Phone

Part 5. Required Parent/Guardian Signatures

Parent or Guardian Release of Health Information.
I give permission to the signing health examiner or facility to share the health information on this form with my child's school, childcare, camp, or Department of Health

PRINT NAME of parent or guardian

SIGNATURE of parent or guardian | *Date*