Dental Exam

Client Name: _____ Appointment Date: _____

Primary Insurance: Medicaid Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Date of Birth: Last Seen: Allergies:

Employee Present at Appt:
Reason for Visit:

Current Medications

Medication	Psychotropic Medication	Dosage & Schedule (i.e. 2mg BID)	Purpose	Continue as is	Med Change

TO BE COMPLETED BY DENTIST:

1. Are there any decaying teeth?	YES	NO
2. Is there gum deterioration?	YES	NO
3. Are there signs of improper brushing?	YES	NO
4. Are obvious signs of infection present?	YES	NO
5. Does the patient need more x-rays?	YES	NO
6. Should an orthodontist be consulted?	YES	NO
7. Are there other abnormalities?	YES	NO
8. Will they need further treatment?	YES	NO

Special Instructions:

Further dental work needed:
Dentists instructions/comments:

It is safe for the above named client to receive PRN over-the-counter medications from certified med aides as specified by ILC's Nurse Consultant. YES NO explain:

Next exam should be scheduled in:_____

Physician Name(print): Physician Signature

	Phone: Fax:

TO BE COMPLETED BY ILC ADMININSTRATION:

Routing: Service Coordination Guardian Vocational Parent

Pharmacy Service Location

Initials	Date