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Dental Evaluation

Name: _____ Date of Appt: _____ Time of Appt.: _____

Facility: _____ Physician/ Providers Name: _____

Ariel Staff Present: _____

To be completed by dentist:

	<u>YES</u>	<u>NO</u>
1. Are there any decayed teeth?	_____	_____
2. Is the gum tissue normal?	_____	_____
3. Do the teeth show evidence of proper brushing?	_____	_____
4. Is there obvious infection?	_____	_____
5. Are further X-rays needed?	_____	_____
6. Should straightening of the teeth be considered?	_____	_____
7. Are other abnormalities present other than malocclusion?	_____	_____
8. Did the patient arrange for necessary treatment?	_____	_____

Comments & Recommendations:

Signature of Evaluator: _____ Date: _____

- Distribution:
- MDS Case Manager
 - Ariel Case File
 - Home File