ADULT ORAL HEALTH SCREENING

Participation is voluntary, information collected on this form will be used for tracking treatment, and services provided to the patient and will be used only for this purpose. See instructions below.

Date of Screening (mm/dd/yyyy) | Site | Initials - Screener
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<table>
<thead>
<tr>
<th>Identification Number</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Race/Ethnicity</td>
<td>5= American Indian/Alaska Native</td>
</tr>
<tr>
<td>1=Male</td>
<td>1= White</td>
<td>7= Multiracial</td>
</tr>
<tr>
<td>2= Female</td>
<td>2= African American</td>
<td>9=Unknown</td>
</tr>
<tr>
<td>= Hispanic/Latino(a)</td>
<td>3= Asian</td>
<td></td>
</tr>
<tr>
<td>4= Asian</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Natural Teeth
0=No Natural teeth
1=Has Natural teeth

Untreated Caries
0=No untreated cavities
1=Untreated cavities

Periodontal Disease Risk Factors or Signs of Inflammation Present
0=No risk factors or signs of inflammation
1=Periodontal risk factors or signs of inflammation present

Treatment Urgency
0=No obvious problem
1=Early dental care
2=Urgent care

Comments

INSTRUCTIONS

1. The Site is the name of the agency.
2. The Identification Number i.e., patient record number
3. Please refer to Basic Screening Surveys: An Approach to Monitoring Community Oral health, 1999, ASTDD, for completing the PARTICIPANT INFORMATION section of the form.

Address any questions to:

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
State Dental Hygiene Officer
1 West Wilson Street
Madison, WI 53702