

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.

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|---|---|--|----------------------------|
| Date of Screening (mm/dd/yyyy) | | Site | Initials - Screener |
| PARTICIPATION INFORMATION | | | |
| Identification Number | | Birth Date (mm/dd/yyyy) | Age |
| Gender 1=Male 2=Female | Race/Ethnicity 1= White 2= African American 3= Hispanic/Latino(a) 4= Asian | 5= American Indian/Alaska Native 6= Native Hawaiian/Pacific Islander 7= Multiracial 9=Unknown | |
| 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