# DHS-1664, YOUTH DENTAL EXAM

Michigan Department of Health and Human Services
Child Welfare Medical Behavioral Health
(Revised 9-21)

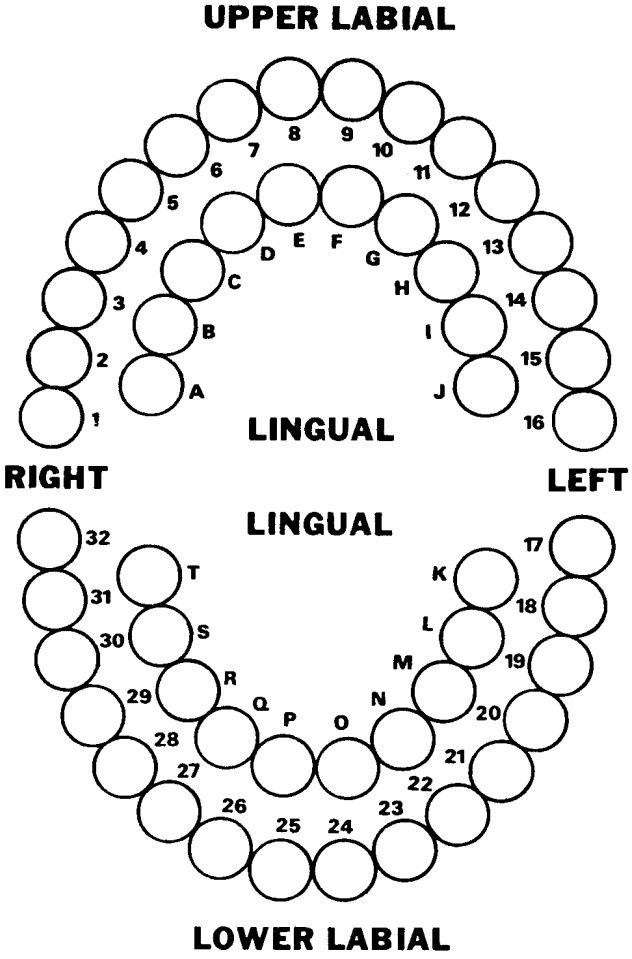
## SECTION 1

Send Report To:
**Fostering Futures (foster care agency)** **Fax#: 734-369-3291**

| Youth's Name | Date of Birth | Treatment Date |
|---|---|---|
| | | |

| Dental Provider Office | Dental Provider |
|---|---|
| | |

## SECTION 2




### DIAGNOSIS

- ☐ Dental Caries
- ☐ Dental Fracture
- ☐ Gingivitis
  - ☐ Mild
  - ☐ Acute
  - ☐ Chronic
- ☐ Malocclusion
- ☐ Missing Teeth
- ☐ Other

### TREATMENT

- ☐ Exam
- ☐ X-Rays
- ☐ Prophylaxis
- ☐ Amalgam or Other Filling
- ☐ Crowns
- ☐ Gingival Curettage or Therapy
- ☐ Extraction
- ☐ Root Canal
- ☐ Fluoride
- ☐ Other

Is treatment complete? ☐ Yes ☐ No

If no, treatment still needed

Next Appointment/Follow Up Appointment Date

Additional Comments

Was a referral made to another dental provider for specialized treatment, e.g. orthodontia, oral surgery, etc.?

☐ Yes ☐ No

If yes, complete information below.

| Provider Name | Provider Address, City, State, Zip Code |
|---|---|

Appointment Date and Time

**Person Completing Form**

| Print Name | Signature |
|---|---|

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