Prenatal/Postnatal Mother Oral Health Assessment

Appointment Date: ___/___/____   Name: ________________________EHS Center: J/ R/ TF   Center:_____________

Provider Setting:  □ Doctor/Dentist/Clinic  □ School/Center  □ Other: Specify ______________________

Flossing Frequency:  □ Daily  □ Weekly  □ Occasionally  □ Never

Number of Times Per Day Patient Brushes Teeth:  ________

Uses Fluoride Toothpaste: □ Yes  □ No  Uses fluoridated mouthwash: □ Yes  □ No  Uses xylitol gum: □ Yes  □ No

Gum Condition:  □ Normal  □ Swollen  □ Bleeds Easily  □ Infected

General Comments on Oral Condition:

Today’s Visit:
Visual Screening
X-Rays
Fluoride Treatment
Oral Hygiene Instruction
Treatment (specify)

Treatment:
No Treatment Needed
Needs cleaning
Needs oral hygiene instruction
Treatment Needed

Next Appointment Date:

Treatment Plan:

Provider Signature:    ________________________________Completion Date: ____/____/_____

Printed Name of Provider: _____________________________
Address: __________________________________________                Phone: ________________