MAP-005 (03/08)

Cabinet for Health and Family Services
Department for Medicaid Services

EPSDT DENTAL EVALUATION FORM

DATE OF RECORDS/EXAMINATION _____ DATE RECEIVED_____
EPSDT

PROVIDER NAME_____ADDRESS_____

TELEPHONE #_____ _____

I. PATIENT INFORMATION

A. NAME_____ BIRTHDATE_____

PARENT OR LEGAL GUARDIAN_____

ADDRESS_____ TELEPHONE_____

CITY_____ STATE_____ ZIP_____

SEX_____ RACIAL/ETHNIC GROUP_____

MEDICAID NUMBER_____

B. CHIEF COMPLAINT (Child/Parent)_____

_____

C. PERTINENT MEDICAL AND DENTAL HISTORY:

CURRENT AND PREVIOUS ILLNESSES (Including Surgery)_____

_____

MEDICATIONS_____

_____

MEDICAL NECESSITY FOR REQUESTED TREATMENT_____

_____

PREVIOUS DENTAL PROBLEMS + TREATMENT_____

_____

II. CLINICAL INFORMATION

A. GENERAL DENTAL EXAMINATION:

OBSERVED STATUS OF DENTAL HEALTH_____

_____

ORAL HYGIENE_____

GINGIVA/PERIO_____

OCCLUSION_____

OTHER PATH_____

III. RADIOGRAPHIC EXAMINATION:

A. PANORAMIC OR FULL MOUTH SERIES:

MISSING OR SUPERNUMERARY TEETH_____

CONDITION OF ROOTS, SUPPORTING TISSUE_____

_____

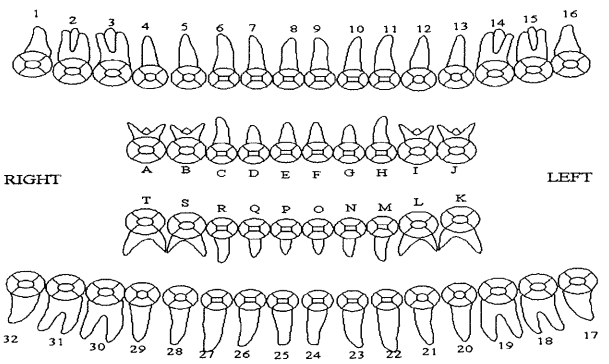
PATHOLOGY_____

_____

ECTOPIC ERUPTION_____

_____

DENTITION:



CODES

CARIOUS - C - 3
ABSCESS - A - A9
NON-RESTORABLE - X - C
MISSING -
RESTORED O - K
DEFECTIVE
RESTORATION O - 30
UNERUPTED U - 32

*PATHOLOGY = RED
RESTORATION = BLUE
(INCLUDE RC & PULP MT)
ALL OTHER = BLACK

IV. SUMMARY:

A. PRIORITIZED PROBLEM LIST:

B. TREATMENT PLAN: (INCLUDE PREVENTIONS, REFERRALS, & FOLLOW-UPS)

C ALTERNATE TREATMENT PLAN : (PRN)

DENTIST

DATE