Future Smiles
Data Collection Form

1. Program Name: **Future Smiles** 2. Event/Site Name: ______________________

3. Patient Name First ______________ Last ______________ 4. Provider Initials: _____

5. Student ID# ______________ 6. Sex _____ (0=Male, 1=Female, 2=unknown) 7. DOB _______

8. Grade: _____ 9. Age: _____ 10. Race/Ethnicity: ___ Asian ___ Black ___ Hispanic ___ White

___ AIAN ___ NHPI ___ Unknown 11. Special health care needs _____ (0=No, 1=Yes)

12. Insurance _____ (0=Medicaid, 1=CHIP, 2=Private, 3=No insurance, 99=blank) __________

12a. Name of Insurance: ______________ 12b. Policy Number: ______________

I. Screening / Services–

D = decay, M = missing (congenital/oral disease), S = sealant present, PS = prescribe sealant, RS = recommend reseal, no mark = no treatment recommended

1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16
32	31	30	T 29	S 28	R 27	Q 26	P 25	O 24	N 23	M 22	L 21	K 20	19	18	17

Circle Answers Below: (B0=No decay, B1= Possible decay B2= Pain, Abscess, or 4 quads of possible decay)

13. Treatment Urgency: B0 B1 B2 14. Sealants Present: Yes No 15. Permanent Teeth Sealed Today: _____

- ☐ Child Prophy **D1120**
- ☐ FL Varnish **D1206**
- ☐ Case Management **D991** **D992** **D993** **D994**

Conditions:

- ☐ Plaque: None Light Moderate Heavy
- ☐ Calculus: None Light Moderate Heavy
- ☐ White Spot Lesions
- ☐ Gingiva: Healthy Red Swollen Bleeding
- ☐ Attrition None Light Moderate Heavy

Referral to DDS/DMD for:

- ☑ Exam – all children are referred to a dentist
- ☐ Orthodontics evaluation by a dentist
- ☐ Possible Abscess: UL UR LL LR
- ☐ Pain: UL UR LL LR

Prescribers Signature **Date:**

II. Sealants and Evaluation

Mark the teeth where sealants were placed with an S

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

III. Follow Up:

Circle retained sealants Number of sealants retained _____ Urgency: 0 1 2

Subsequent Restorative Treatment: Yes No Fluoride Treatment Received: Yes No

Retention Check Signature **Date:**