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## 's Family Services

rm to Your Regional Office)

### *ntal Examination*

Name:______________________________ Foster Parents:______________________________

Date of Birth:______________ Age:__________ Address:______________________________

Social Worker:______________________________ ______________________________

Insurance Company:______________________________ Telephone Number:______________________________

Policy Number:______________________________ Medicaid Number:______________________________

Teeth:______________________________________________________________

______________________________________________________________

Gums:______________________________________________________________

______________________________________________________________

Oral Hygiene:______________________________________________________________

______________________________________________________________

Recommendations:______________________________________________________________

______________________________________________________________

______________________________________________________________

| ______________________________ | ______________________________ | ______________________________ |
|---|---|---|
| Physician's Signature | Date of Examination | Phone Number |
| ______________________________ | ______________________________ | ______________________________ |
| Physician's Name (please print) | Clinic Name | ______________________________ |
| | | Office Address |