



Review Questions

1. At what age should a child be referred for their first dental visit?
2. How often should a child in CHDP see a dentist for a routine dental exam and preventive dental treatment?
3. How would you classify and document the following dental assessment?
(Fill in the PM160 form below.)



DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY



PATIENT NAME (LAST) (FIRST) (INITIAL)			MEDICAL RECORD NO.			LA Code		94 XXXXXXXX J		
Mo.	Day	Year	AGE	SEX M/F	PATIENT'S COUNTY OF RESIDENCE	CO. CODE	TELEPHONE NUMBER	Mo.	Day	Year
RESPONSIBLE PERSON (NAME)			(STREET)			(APT./SPACE #)	(CITY)	(ZIP)		
Ethnic Code										
<input type="checkbox"/> 1-American Indian <input type="checkbox"/> 2-Asian <input type="checkbox"/> 3-Black <input type="checkbox"/> 4-Filipino <input type="checkbox"/> 5-Mex. Amer./Hispanic <input type="checkbox"/> 6-White <input type="checkbox"/> 7-Other <input type="checkbox"/> 8-Pacific Islander										

CHDP ASSESSMENT Indicate outcome for each screening procedure	NO PROBLEM SUSPECTED √ A	REFUSED, CONTRA-INDICATED, NOT NEEDED √ B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column		DATE OF SERVICE Mo. Day Year	FEEES	FOLLOW UP CODES	
			NEW C	KNOWN D			1. NO DX/RX INDICATED OR NOW UNDER CARE.	4. DX PENDING/RETURN VISIT SCHEDULED.

01 HISTORY and PHYSICAL EXAM							01	REFERRED TO:	TELEPHONE NUMBER	
02 DENTAL ASSESSMENT/REFERRAL								REFERRED TO:	TELEPHONE NUMBER	
03 NUTRITIONAL ASSESSMENT										
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION										
05 DEVELOPMENTAL ASSESSMENT										
06 SNELLEN OR EQUIVALENT							06			
07 AUDIOMETRIC							07			
08 HEMOGLOBIN OR HEMATOCRIT							08			
09 URINE DIPSTICK							09			
10 COMPLETE URINALYSIS							10			
12 TB MANTOUX							12			
CODE	OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES					CODE	OTHER TESTS		

REFERRED TO:	TELEPHONE NUMBER
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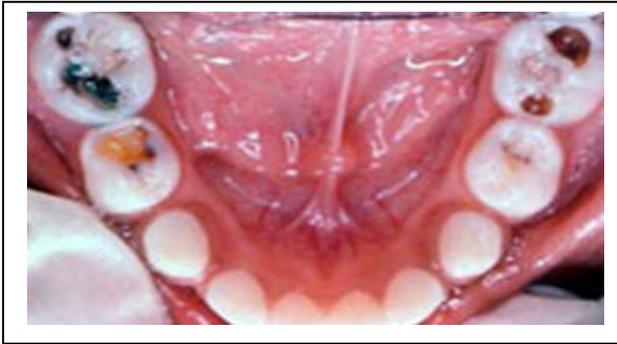
COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

HEIGHT IN INCHES	WEIGHT LBS	OZS	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE										
0	4													
HEMOGLOBIN	HEMATOCRIT		BIRTH WEIGHT LBS	OZS										
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C	D													

ROUTINE REFERRAL(S) (✓)	PATIENT IS A FOSTER CHILD (✓)
<input type="checkbox"/>	<input type="checkbox"/>
BLOOD LEAD	DENTAL
DIAGNOSIS CODES	
1	2

4. How would you classify and document the following dental assessment?
(Fill in the PM160 form below.)



DO NOT STAPLE
IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

8
STAPLE
HERE

P L I M S T R I M E N T	PATIENT NAME (LAST) (FIRST) (INITIAL)			MEDICAL RECORD NO.			LA Code	94	XXXXXXXXX	J
	Mo.	Day	Year	AGE	SEX M/F	PATIENT'S COUNTY OF RESIDENCE	CO. CODE	TELEPHONE NUMBER	NEXT CHDP EXAM	Mo. Day Year
	RESPONSIBLE PERSON (NAME)			(STREET)			(APT./SPACE #)	(CITY)	(ZIP)	Ethnic Code

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HEMOGLOBIN	HEMATOCRIT		BIRTH WEIGHT LBS	OZS
		.0%		

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<input type="checkbox"/> BLOOD LEAD	<input type="checkbox"/> DENTAL

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DIAGNOSIS CODES	
1	2

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Tobacco Used by Patient	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Counseled About/Referred For Tobacco Use Prevention/	Yes <input type="checkbox"/>	No <input type="checkbox"/>

PATIENT VISIT (✓)	TYPE OF SCREEN (✓)	TOTAL FEES
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5. How would you classify and document the following dental assessment?
(Fill in the PM160 form below.)



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