Date: _______   Office/Clinic: ____________________________________    County: __________________

I am a: □ Physician □ Nurse Practitioner □ Nurse □ Physician Assistant □ MA
□ Other Staff (specify) _______________ □ Dental Professional (specify) _______________

1. After this presentation, are you more confident in your ability to perform an oral health assessment?
   □ YES □ NO □ Need More Training
   Comment: _______________________________________________________________________________

2. Will you refer children to the dentist at least annually beginning at age one?
   □ YES □ NO
   Comment: _______________________________________________________________________________

3. Are you more confident classifying the dental condition of your patients and documenting on the PM160?
   □ YES □ NO
   Comment: _______________________________________________________________________________

4. Will you offer fluoride varnish application for children under 6 who are at risk for dental caries?
   □ YES □ NO
   Comment: _______________________________________________________________________________

5. Would you like additional training on fluoride varnish application?
   □ YES (provide contact information below) □ NO

6. Do you need clarification on any of the following sections of the training? (Check all that apply)
   □ Risk Assessment □ Fluoride Assessment □ Oral Assessment
   □ Anticipatory Guidance □ Documentation □ Referral
   Comment: _______________________________________________________________________________

7. Which guides and brochures referenced in this training will you download and/or print:
   □ Oral Health for Infants & Toddlers □ PM160 Dental Guide
   □ CHDP/CCS Orthodontic & Craniofacial Referral Guide
   Brochures: □ Fluoride Varnish □ Every Child Needs a Dental Home □ Prevent Tooth Decay in Babies and Toddlers
   □ Growing Up Healthy (14 age specific brochures)
   Other: ________________________________________________________________________________

8. Would you recommend this presentation to other health care providers?
   □ YES □ NO
   If no, what would make this presentation better? _______________________________________________________________________________

9. If you would like more dental resources please give your contact information:
   Name _____________________ Phone ___________________ Email ____________________________

   Thank you!