RIVERSIDE COUNTY DEPARTMENT OF PUBLIC SOCIAL SERVICES
REPORT OF DENTAL EXAM

FOR HEALTH PASSPORT UPDATE
RETURN IN THE POSTPAID ENVELOPE.

CHILD:
CASE #:
DOB:
WORKER NAME:

TO BE COMPLETED BY THE DENTAL PROVIDER: ICD-9 (IF EASILY AVAILABLE)

PLEASE FILL OUT OR ATTACH A BUSINESS CARD PLEASE:

DENTIST'S NAME: _____

ADDRESS: _____

CITY/STATE: _____

TELEPHONE: ( ) _____

Date of Visit:

Results of exam and/or Diagnosis given:

Treatment:

TYPE OF VISIT: ☐ ROUTINE COMPREHENSIVE:_____

☐ FOLLOW UP:_____ ☐ SICK VISIT:_____
☐ CHECK UP:_____ ☐ Tx ONGOING:_____
☐ Tx COMPLETED:_____ ☐ SPECIALIST VISIT:_____
☐ MEDICATIONS PRESCRIBED:_____

WAS CHILD REFERRED TO ANOTHER PROVIDER? ☐ NO ☐ YES (If Yes, please complete)

NAME:_____ SPECIALTY: _____

ADDRESS: _____ TO BE SEEN WHAT DATE: _____

TELEPHONE: ( ) _____

REASON FOR REFERRAL: _____

RETURN TO: KRISTEN THOMPSON, PUBLIC HEALTH NURSE
DPSS CHILDREN'S SERVICES
11070 MAGNOLIA AVE. STE A
RIVERSIDE, CA 92505
PH: (951) 358-5667 FAX: (951) 358-5414