MAP-396 (REV. 03/01)

KENTUCKY MEDICAID PROGRAM
ORTHODONTIC EVALUATION FORM

Date of Records/Examination _____ Date Received _____

I. Approval_____ Disapproval _____ Total Treatment Fee_____

II. Patient Information:

A. Name _____ Birthdate _____
Parent or Legal
Guardian _____
Address _____
Telephone _____
Sex _____ Racial/Ethnic Group _____

B. KY Medical Assistance Card Number _____

C. Chief Complaint _____

D. Pertinent Medical and Dental History:

III. Clinical Examination:

IV. Radiographic Examination:

Radiographic Examination:

V. Cast Analysis:

VI Summary:

A. Prioritized Problem List:

B. Treatment Plan:

EDS
ORTHODONTIC PROGRAM
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FRANKFORT, KENTUCKY 40602