LAKEWOOD CITY SCHOOLS

DENTAL HEALTH RECORD

Lakewood Early Childhood Program
13701 Lake Ave • Lakewood, OH 44107
Phone 216-529-4214 • Fax 216-529-4104

Child's Name _____ Date of Birth: _____

Has child previously seen a dentist? Yes ☐ No ☐ Dentist's name: _____

Date of last visit: _____

Is child under a physician's care? Yes ☐ No ☐ Physician's name: _____

Is child receiving medication? Yes ☐ No ☐ If so, what type? _____

Child is reported to have:							
	Allergies	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
	Heart/Vascular Disease	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐
	Liver Disease	Yes ☐	No ☐	Bleeding	Yes ☐	No ☐
	Rheumatic Fever	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
	Sickle Cell Disease	Yes ☐	No ☐	Other	Yes ☐	No ☐

If yes, include length of time receiving fluoride

Is the child now receiving topical fluoride application? Yes ☐ _____ No ☐ Unknown ☐

Is the child now receiving fluoridated water? Yes ☐ _____ No ☐ Unknown ☐

Is the child now receiving fluoride supplement diet? Yes ☐ _____ No ☐ Unknown ☐ tablet ☐ liquid

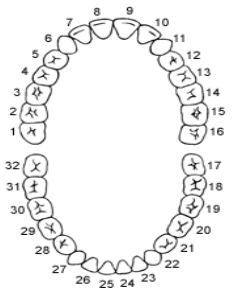
TO BE COMPLETED BY DENTIST

Oral conditions before treatment:

Missing ⊗

Decayed ●

Filled ⊗



Examination and Treatment Record (list recommended services in order.)

Tooth # or Letter	Surfaces	Description of work	Treatment Approved	Date Services Performed	A.D.A Procedure Number	Actual Charges

Dental Needs:

Does the child have any trouble with teeth, gums or mouth other than the parent knows about?

☐ No Problems ☐ Cleaning ☐ Fluoride ☐ Treatment (restoration, pulp therapy, extraction)

Child Oral Health Summary: All planned treatment(s) ☐ Complete ☐ Not complete

If not, explain here as well as items checked _____

☐ Routine recall visits ☐ Dietary problem(s) ☐ Special home emphasis, oral hygiene

☐ Harmful oral habits ☐ Developmental problem(s) ☐ Needs fluoride supplement

I certify that I have completed the service(s) recommended for the child.

Dentist Signature: _____ **Date:** _____

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