CHILD DENTAL HEALTH RECORD

PART I. To Be Completed Before visit by Parent or Guardian.

CHILD'S NAME._____ SEX. _____ BIRTH DATE:_____

HEAD START CENTER _____ PUBLIC PRESCHOOL SITE_____

ADDRESS:_____ PHONE: _____

Dentist Address

1. IS THE CHILD NOW RECEIVING :

Topical Fluoride Application?	No____	Unknown____	Yes_____
Fluoride water?	No____	Unknown____	Yes_____
Fluoride Supplement diet?	No____	Unknown____	Yes_____

(tablets_____, liquid____)

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT? I.E: CAPS.

Previous Dental Treatment._____

_____

_____

3. CHILD (__HAS, ___ HAS NOT) PREVIOUSLY SEEN A DENTIST.
Dentist's name_____ Date of last visit _____

4. CHILD (____ IS, _____ IS NOT) UNDER A PHYSICIAN'S CARE
Physicians's name _____

5. CHILD (___ IS, ____ IS NOT) RECEIVING MEDICATION.
Type _____

6. Please list any Allergies to Medication or Food.

_____

_____

_____

_____

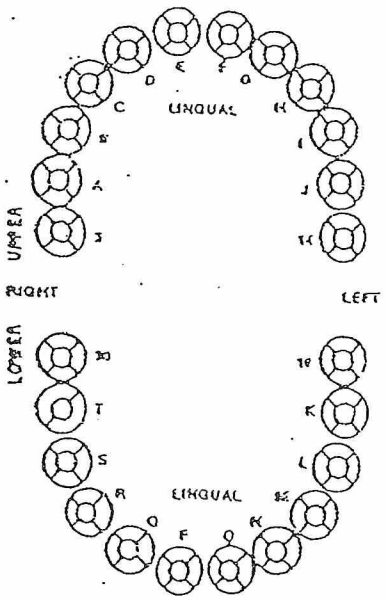
Dentist Name

7. CHILD IS REPORTED TO HAVE (Give details or attach Health History)

	YES	NO		YES	NO
Allergies	____	____	Liver Dis.	____	____
Asthma	____	____	Rheumatic Fever	____	____
Bleeding	____	____	Sickle Cell Dis.	____	____
Diabetes	____	____	Other (List Below)	____	____
Epilepsy	____	____	_____		
Heart/Vascular Dis.	____	____	_____		

Part II. To Be Completed by Dentist.

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (◯), or filled (▣): Indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)	

11. Dental Needs: _____A. Treatment (restoration, pulp therapy, extraction) _____B. Cleaning _____C. Fluoride _____D. Other _____E. No Problems

Approximate number of visits _____. Approximate cost _____.

12. Child oral Health Summary (complete and return)
All planned treat (___ is, ___ is not) complete. If not, explain here are well as items checked.

_____

_____ a. Routine recall visits _____ b. Special home emphasis, oral hygiene _____ c. Dietary problems)
_____ d. Developmental problem(s) _____ e. Harmful oral habits _____ f. Needs fluoride supplement

I certify that I have completed the service(s) listed in Part II, item 10, and that itemized charges do not exceed my ususal and customary fees.

Signature Date