Dental Record

Child's Name_____ Gender: ☐ M ☐ F DOB: _____

Parent/Guardian's Name: _____ Phone #:_____

Dentistry Practice Name & Address: _____

Is this practice the child's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the child have any teeth:

1. With untreated decay? ☐ Yes (decay) ☐ No (decay free)
2. Previously treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Does the child have gum disease? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needed

Oral Health Care Services Delivered During Visit

Examination Date: _____

Did the child receive the following at this appointment *(if necessary, please use back side to explain)*:

X-rays:	☐ Yes ☐ No	Fillings:	☐ Yes ☐ No
Risk assessment:	☐ Yes ☐ No	Crowns:	☐ Yes ☐ No
Cleaning:	☐ Yes ☐ No	Extractions:	☐ Yes ☐ No
Fluoride varnish:	☐ Yes ☐ No	Emergency care:	☐ Yes ☐ No
Dental sealants:	☐ Yes ☐ No	Other (please specify):	_____

Counseling/Anticipatory Guidance: ☐ Yes ☐ No

Referral to Specialty Care: ☐ Yes ☐ No If yes, Specialist's Name:_____

Future Oral Health Care Services

All planned treatment is completed: ☐ Yes ☐ No

Follow-up appointment necessary: ☐ Yes ☐ No Appointment date:_____

Comments/Notes:

I certify that the above services and treatments are completed.

_____ _____

Provider Signature *Date*