Dental Form

Name of Child ____Male ____Female	
Date of birth	
Child's current age	
Parent(s)/Guardian Name	

1. Is the child now receiving any of the following? If "yes", include length of time receiving fluoride.
   Topical fluoride application ___No ___Unknown ___Yes
   Fluoridated water ___No ___Unknown ___Yes
   Fluoride supplement diet ___No ___Unknown ___Yes
   ____Tablets ____Liquid

2. Does the child have any of the following? If "yes" provide details.
   Allergies ___Yes ___No
   Asthma ___Yes ___No
   Bleeding ___Yes ___No
   Diabetes ___Yes ___No
   Epilepsy ___Yes ___No
   Heart/Vascular disease ___Yes ___No
   Liver disease ___Yes ___No
   Rheumatic fever ___Yes ___No
   Sickle cell disease ___Yes ___No
   Other (Please list)_____

3. Does the child have any trouble with teeth, gums or mouth? ___Yes ___No
   If so, what kind? _____

4. Child has previously seen a dentist? ___Yes ___No
   Dentist Name_____Date of last visit_____

5. Child is under a physician's care? ___Yes ___No
   Physician Name _____

6. Child is receiving medicine? ___Yes ___No

7. PLEASE PROVIDE A <u>WRITTEN SUMMARY OF SERVICES REQUIRED</u> (on the back of this form):
   *for the relief of pain or infection
   *restoration and/or pulp therapy of decayed primary and permanent teeth
   *extraction of non-restorable teeth
   *dental prophylaxis & instruction in self-care oral hygiene procedures

Dentist Name (Print)	
Complete Address	
Phone	
License No.	Tax ID No.

EXAMINATION AND TREATMENT RECORD

List recommended service in order.

Priority Group: ____ Needs Attention Immediately
____Needs attention soon
____Needs Routine Care

Dental Needs: ___Treatment (restoration, pulp therapy, extraction)
____Cleaning____Fluoride____No Problem
____Other: _____

Tooth #/ Letter	Surfaces	Description of work	Treatment Approved	Date of Services Performed			ADA Procedure #	Actual Charges	

Approximate number of visits: _____ Approximate cost: _____
This is an accurate determination of services required.

Dentist Signature _____ Date _____

All planned treatment [___is ___is not] complete. If not, explain here:

The following services were provided. Explanation of each included with this report.
___Routine recall visits ___Special home emphasis, oral hygiene
___Dietary problem(s) ___Developmental problem(s)
___Harmful oral habit ___Needs fluoride supplement

I certify that I have completed the service(s) listed on this page and the services as marked. Itemized charges do not exceed my usual and customary fees.

Dentist Signature_____ Date_____