CHILD DENTAL RECORD

PART I:

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

Head Start Campus: _____ PHONE: _____

DENTIST NAME: _____ ADDRESS: _____

PHONE #:_____FAX:_____

PART II:

EXAMINATION AND TREATMENT RECORD (List recommended services).

ORAL CONDITIONS BEFORE TREATMENT

Examination and treatment plan, In order from tooth 1 through 32							
Tooth	Surface	Description of service	Date Services			ADA	Fee
		EXAM (1st Visit Only)					
		Fluoride					
		Cleaning					

DENTAL NEEDS: At the time of the initial exam list all services / treatment the child needs in the area above. Include if the child needs cleaning, flouride and/or x-rays. Date the service on the day it is completed.

PART III: INSTRUCTION/ PROBLEMS

☐ Routine recall visits ☐ Dietary problems ☐ Harmful oral habits

☐ Special home emphasis oral hygiene ☐ Developmental problems ☐ Needs flouride supplement

Instruction given:_____

PART IV: TREATMENT PLAN: (complete this section only if child requires treatment/ follow-up)

_____ _____

Next appointment est. # of visits to complete

All planned treatment is not complete. _____ _____.

Dentist Signature Date

PART V: SERVICES COMPLETE:

I certify that I have completed the services listed in Part II and that the itemized charges do not exceed my usual and customary fees.

_____ 12/11/18

Dentist Signature Date

Revised 11-1-18