DENTAL HEALTH RECORD

Maple Heights City Schools
Early Childhood Program – Public Preschool

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____
ADDRESS: _____ PHONE:_____

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:

	Yes	No		Yes	No
Allergies	____	____	Heart/Vascular Disease	____	____
Asthma	____	____	Liver Disease	____	____
Bleeding	____	____	Rheumatic Fever	____	____
Diabetes	____	____	Sickle Cell Disease	____	____
Epilepsy	____	____	Other _____		

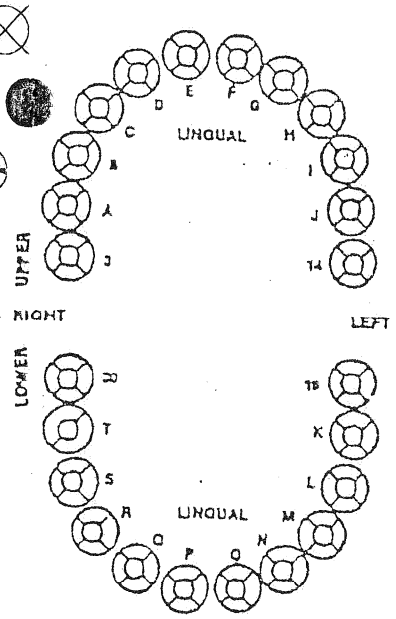
If "yes" include length of time receiving fluoride

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?
(tablets _____, liquid _____) _____ Yes _____ No ____ Unknown

TO BE COMPLETED BY DENTIST

Oral conditions before treatment:

Missing ⊗
Decayed ●
Filled ⊖



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

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: _____ Treatment (restoration, pulp therapy, extraction) _____ Fluoride _____Other
_____ Cleaning _____ No problems
Approximate number of visits _____ Approximate cost _____

CHILD ORAL HEALTH SUMMARY:
All planned treatment(s) _____is _____is not complete. If not, explain here as well as items checked. _____

____ Routine recall visits
____ Special home emphasis, oral hygiene
____ Dietary problem(s)
____ Developmental problem(s)
____ Harmful oral habits
____ Needs fluoride supplement

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

Signature:_____ Date: _____