CHILD HEALTH RECORD DENTAL HEALTH

Child's Name:_____ Sex:_____ Birthdate:_____

Address:_____ Phone:_____

1. Is the child now receiving: 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 trouble with teeth, gums, or mouth than the parent knows about?

3. Child ___Has ___Has Not previously seen a dentist.

Dentist's name _____ Date last visit_____

4. Child ___IS___IS NOT under a physician's care

Physician's name_____

5. Child ___IS___IS NOT receiving medication

Type_____

6. 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.	___	___	_____		

7. Source of Reimbursement or services

_____EPSDT/Medicaid

_____Federal, State, or local agency _____

_____Head Start

_____In-Kind Provider _____

_____Parents/Guardians

_____Other (3rd party)_____

8. Priority group

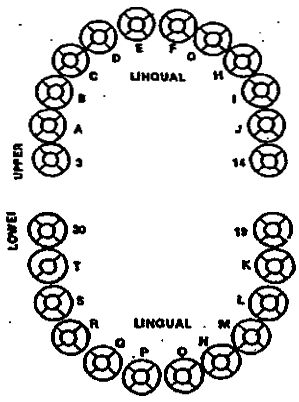
_____Needs attention immediately

_____Needs attention soon

_____Needs routine care

9. Oral Conditions Before Treatment: missing, decayed or filled

Indicate restorations you perform in Item 10.



10. Examination and treatment record (List recommended service 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

_____ Treatment (restoration, pulp therapy, extraction) _____ Cleaning

_____ Fluoride _____ Other

_____ No problems

Approximate number of visits _____ Approximate cost_____

12. Child Oral Health Summary

All planned treatment (___IS, _____IS NOT) complete. If not, explain here, as well as items checked.

_____

_____

_____Routine recall visits _____Dietary problem(s) _____Harmful oral habits

_____Special home emphasis, oral hygiene _____Developmental problem(s) _____Needs fluoride supplement

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

Signature_____ Date_____