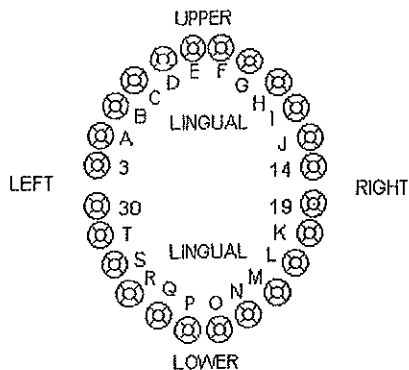


Name _____ DOB _____

Provider Setting Doctor/clinic School/clinic Other _____

Current Dental Status:



Key: Missing Decayed Filled

Dental Concerns- Provider / Parent None

- Tooth Decay Gingivitis/Mucosal infection Development disturbances (tooth formation)
- Brushing times/technique Flossing schedule Thumb sucking Bottle use Discolored teeth

Dental Services / Needs	Provided this Visit	Schedule Treatment Date
Cleaning	<input type="checkbox"/>	_____
Fluoride treatment	<input type="checkbox"/>	_____
Sealant/ Pulp Therapy	<input type="checkbox"/>	_____
Extraction	<input type="checkbox"/>	_____
Restoration	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	_____

Anticipatory Guidance Provided:

- Growth/Development (diet & nutrition's impact on teeth)
- Need for regular brushing/flossing for age
- Injury Prevention/Dental Emergency information
- Need for six-month routine follow-up Date scheduled _____

Provider Signature _____ Date _____
Provider Name _____ Phone _____

Provider may substitute own form but PLEASE include dates of scheduled or completed work.