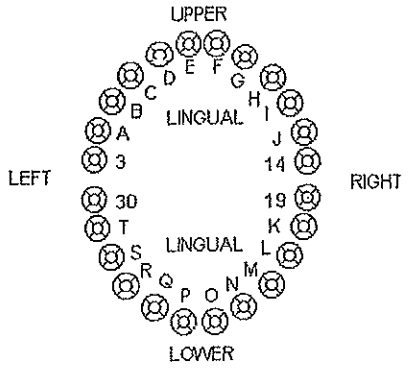
Name_____DOB_____

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	☐	_____
Fluoride treatment	☐	_____
Sealant/ Pulp Therapy	☐	_____
Extraction	☐	_____
Restoration	☐	_____
Other_____	☐	_____

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.