# Dental Form

Child's Name _____ Sex: M ____ F _____ Birth Date: _____
Address: _____ Phone: _____
Preschool Site: _____

## Dental Status

1. Has your child been to the dentist? No _____ Yes ____ Date:_____
2. Is your child now receiving:
   - Topical Fluoride Application — Yes____ No_____
   - Fluoridated Water — Yes____ No_____
   - Fluoride Supplement (__tablet ___liquid) — Yes____ No _____
3. Are you aware of any trouble with your child's teeth, gums, or mouth? No___ Yes ___(explain)_____
4. Do you have dental insurance? Yes___ No___

Dentist Name: _____

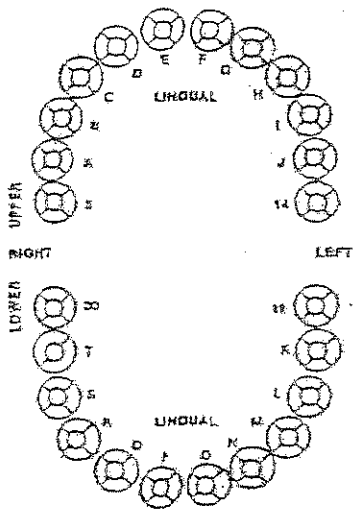
Address_____ Phone: _____

Dental Needs: Treatment (specify _____) Cleaning _____ Fluoride _____
Other_____

The following oral hygiene instruction was provided:
Tooth brushing _____ Flossing _____diet counseling as related to dental health
_____ home/school use of fluoride mouth rinse

The following statements are applicable:
_____ All necessary services have been performed
_____Date of next appointment _____ Further treatment is indicated

ORAL CONDITIONS BEFORE TREATMENT: *missing ( ), decayed ( ), or filled ( ); indicate restorations*




EXAMINATION AND TREATMENT RECORD *(List recommended services 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) |
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Dentist's Signature _____ Date ____/____/____