DENTAL HEALTH RECORD

Child's Name	Birth Date	Classroom/Home Visitor
Address		

❑ **Routine Exam**:

Date of Exam	Cleaning ❑Yes ❑No	Fluoride ❑Yes ❑No	X-rays ❑Yes ❑No
Next Checkup Appointment Date	Is Dental Treatment Needed? ❑Yes ❑No		
Referred to:			
Check if unable to examine at this time ❑	Reason		

❑ **Dental Treatment**:

All treatment complete? ❑Yes ❑No	Date Treatment Completed	Next Treatment Appointment Date if additional work is required:	
Treatment: Fillings ❑	Crowns ❑	Extractions ❑	Other ❑

Comments or Recommendations:

I certify that the services listed above have been performed.

_____ _____

Dental Provider Signature Date

_____

Dental Office/Practice Name & Address (Print or Stamp)