CHILD HEALTH RECORD: FORM 5, DENTAL HEALTH

CHILD'S NAME:_______________________________________ SEX:_________
BIRTHDATE:_________________

ADDRESS:_________________________________
PHONE:___________________________________

1. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAT THE PARENT KNOWS ABOUT?

2. PAYMENT/INSURANCE INFORMATION:

Tooth # or Letter | Surfaces | Description of Work | Treatment Approved | Date Services Performed

MO. DAY YR. | A.D.A. Procedure Number | Actual Charges (Fee)

4. EXAMINATION AND TREATMENT RECORD (*List recommended services in order)*

CHILD HEALTH RECORD: FORM 5, DENTAL HEALTH

<u>DATE</u> DENTAL SERVICES PROVIDED: ________________

EXAM _____ FLUORIDE _____ PROPHY _____ X-RAYS _____ SEALANTS _____

TREATMENT (restoration, pulp therapy, extraction, etc) _____ *(See section below if treatment is <u>not</u> complete)*

OTHER ____ **DATE OF NEXT ROUTINE EXAM:** _________________

DENTAL SERVICES NEEDED:

EXAM _____ FLUORIDE _____ PROPHY _____ X-RAYS _____ SEALANTS _____ OTHER _____

TREATMENT (restoration, pulp therapy, extraction, etc) _____ REFERRAL _____

Approximate number of visits to complete treatment: _____

Dates of scheduled appointment(s):____

SUMMARY OF DENTAL SERVICES:

_____ All planned treatment **is** complete _____ Treatment was Referred

_____ All planned treatment **is NOT** complete _____ No treatment needed at this time; routine recall visits

Provider Signature ____ **Date** _________________