DENTAL EXAMINATION & TREATMENT RECORD

Child's Name_____ Center_____
Parent/Guardian_____ Center Phone_____
Medical Card Number_____ Center Address_____
_____

Dentist Name_____ Phone_____

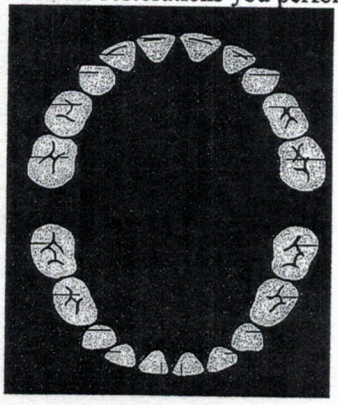
Address_____

1. EXAMINATION:

ORAL CONDITIONS BEFORE TREATMENT:

Missing ☐ Decayed ☐ Filled ☐

Indicate restorations you perform in Item 2



2. TREATMENT PLAN/RECORD

Tooth # or Letter	Surface	Description of Work	Date Preformed

3. CHILD ORAL HEALTH SUMMARY: (complete and return to preschool after each visit).

All planned treatment:
_____is complete
_____is not complete Follow up needed: _____

Next Scheduled appointment: _____

_____ _____
Dentist's Signature Date of Service