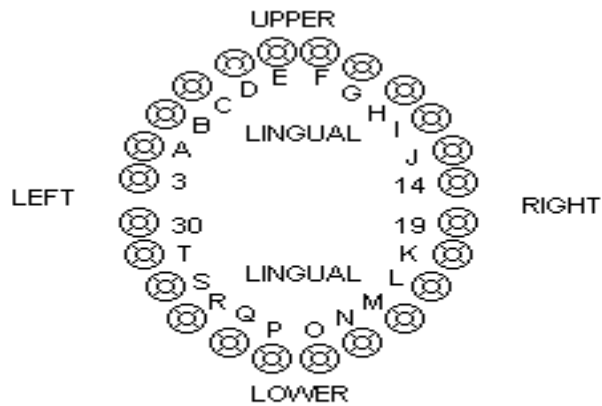




Child's Name _____ Date of Exam _____

DOB _____



Key:  Missing  Decayed  Filled

Services provided at visit (Mark all that apply):

___ Exam ___ Cleaning ___ Sealants ___ Fluoride
 ___ Other: please list _____

Dental Needs(Mark all that apply)

___ No needs ___ Fluoride Supplement ___ Further treatment needed (please list): _____
 ___ Other: please list: _____

Overall Condition(Circle one)

Healthy oral condition Moderate oral condition Fair oral condition Poor oral condition



Education/Instructions (Mark all that apply)

Oral hygiene Weaning off bottle Baby Bottle Caries Nutrition
 Other: please list _____

Treatment/Follow-up

No further treatment needed, **return in 3 or 6 months (circle one)** for routine care and treatment

Follow-up needed in _____ days, weeks, months (circle one)

Type of treatment needed (mark all that apply):

Extraction

Surgery

Crowns

Fillings

Other (please list): _____