Child's Name___________________________ Date of Exam_________

DOB____________

UPPER

D E F G H I J C B A 3 14

LINGUAL

LEFT RIGHT

30 19 T K S L R M Q N P O

LINGUAL

LOWER

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):_______________________