Perry-Hocking ESC - Early Childhood Program
Dental Form

Child's Name _____ **Sex: M** ____ **F** _____ **Birth Date:** _____
Address: _____ **Phone:** _____
Preschool Site: _____

Dental Status

1. **Has your child been to the dentist?** No _____ Yes ____ Date:_____

2. **Is your child now receiving:**
   Topical Fluoride Application Yes____ No_____
   Fluoridated Water Yes____ No_____
   Fluoride Supplement (__tablet ___liquid) Yes____ No _____

3. **Are you aware of any trouble with your child's teeth, gums, or mouth?** No___ Yes ___(explain)_____

4. **Do you have dental insurance?** Yes___ No___

Dentist Name: _____

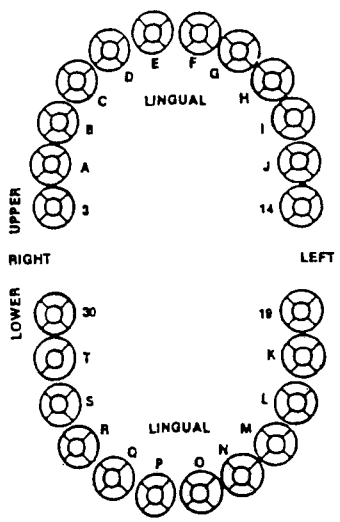
Address _____ **Phone:** _____

Dental Needs: Treatment (specify _____**) Cleaning** _____ **Fluoride** _____
Other _____

The following oral hygiene instruction was provided:
Tooth brushing _____ **Flossing** _____**diet counseling as related to dental health**
_____ **home/school use of fluoride mouth rinse**

The following statements are applicable: _____ **All necessary services have been performed**
_____**Date of next appointment** _____ **Further treatment is indicated**

ORAL CONDITIONS BEFORE TREATMENT: *missing ( ), decayed ( ), or filled ( ); indicate restorations*



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

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)	

Dentist's Signature _____ **Date** ____/____/____