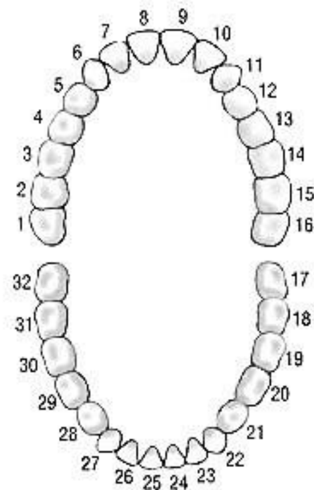
Mid- East Children's Learning Center Dental Exam Form

400 Richards Road Zanesville, Ohio 430701
FAX NUMBER: 740-454-0723 ATTN: CHILDREN'S LEARNING CENTER

Child's Name (print or type)	**Date of Birth**
Parent's Name	**Preschool: Mid-East Children's Learning Center**

Is the child now receiving any of the following?

(If yes, include length of time receiving fluoride)
Topical fluoride application: ___ No ___ Unknown ___ Yes _______________
Fluoridated water: ___ No ___ Unknown ___ Yes _______________
Fluoride supplement diet: ___ No ___ Unknown ___ Yes _______________
_____ Tablets _____ Liquid
Does the child have any trouble with teeth, gums or mouth? ___Yes ___No
If so, what kind? ___________________________________
Has the child previously seen a dentist? ____Yes ____ No
Dentist Name _________________________ Date of last visit _________________
Is child under physician's care? ____ Yes ____ No
Physician Name ____
Is child receiving medication? ____ Yes ____ No



Services provided this visit:

Tooth Number Description of work
______________ ________________________________
______________ ________________________________
______________ ________________________________

Is follow-up required? ___Yes ___ No **(If yes, see section below)**

Name Of Dentist	**Telephone Number ( )**
Street Address	
Dentist Signature	**Date Signed**

****PLEASE COMPLETE THIS SECTION FOR FOLLOW-UP REQUIREMENTS:****

Please provide a written summary of the following services required:

* For the relief of pain or infection
* Restoration and/or pulp therapy of decayed permanent teeth
* Extraction prophylaxis & instructions in self-care oral hygiene procedures

Recommended follow-up dental needs (check all that apply):

( ) A. Treatment (restoration, pulp therapy, extraction)
( ) B. Cleaning
( ) C. Fluoride
( ) D. Other (please specify below)

____

Approximate number of visits need to be complete care __________________________________

Has a follow-up appointment been scheduled? ___ Yes ___ No Date: ______________