CLEVELAND METROPOLITIAN SCHOOL DISTRICT

CHILD'S HEALTH RECORD

DENTAL EXAM

CHILDS NAME: ________________________________ SEX__________ DOB__________

1. Is the child now receiving:

If yes, include length of time receiving fluoride.

Topical Fluoride Application	YES	NO	UNKNOWN
Fluoride Water			
Fluoride Supplement diet (Tablets __ Liquid __)			

2. Does the child have any trouble with teeth, gums, or mouth than the parent knows about? Yes_ No_
3. Child has previously seen Dentist? Yes_ No_ Dentist Name______________ Last visit date_______
4. Child is under Physician's Care? Yes_ No_ Physician's Name______________________________
5. Child is receiving medication? Yes_ No_ Type:____________________________________
6. Child is reported to have:

Give details/attach Health History if necessary

	YES	NO
Allergies		
Asthma		
Bleeding		
Diabetes		
Epilepsy		
Heart/Vascular Disease		
Liver Disease		
Rheumatic Fever		
Sickle Cell Disease		
Other, please explain →		

7. Source of reimbursement or Services

_ EPSOT/Medicaid
_ Federal, State, or local Agency
_ Head Start
_ In-Kind Provider
_ Parents/Guardians
_ Other (3rd Party)

8. Priority Group

_ Needs Attention Immediately
_ Needs Attention Soon
_ Needs Routine Care

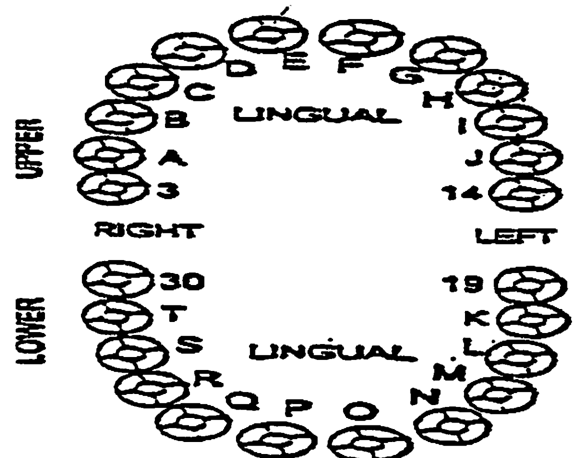
9. Oral conditions before treatment:

Indicate restorations you perform in item 10

MISSING ⊗

FILLED ⊕

DECAYED ∅



*Turn to the back

10. **Examination and Treatment record (list recommended services in order**

Tooth #/Letter	Surfaces	Description of work	Treatment Approved	Date Service Performed (yy/yy/yyyy)	A.D.A. Procedure Number	Actual Charges (fee)

11. **Dental Needs:**

- € Treatment (restoration, pulp therapy, extraction)
- € Cleaning
- € Fluoride
- € Other:_______________________
- € No Problems

Approximate number of visits ______________________ Approximate cost________________

12. **Child Oral Health Summary**

All planned treatment is complete? Yes_ No_ If not, please explain here, as well as the items that are checked. ____

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- € Routine recall visits
- € Dietary problem (s)
- € Harmful oral habits
- € Special home emphasis, oral hygiene
- € Developmental problem (s)
- € Needs Fluoride Supplement

I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

Signature____ Date ________________