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)

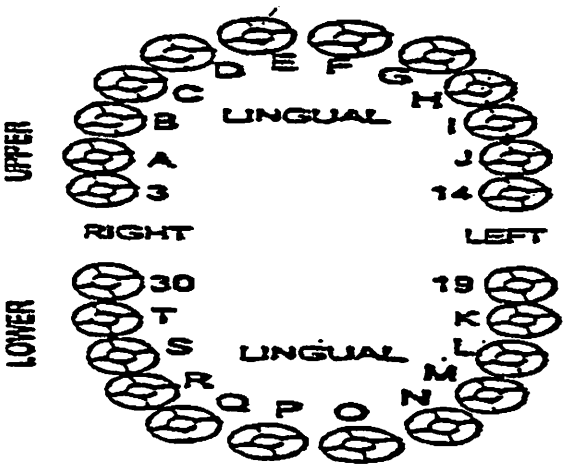
8. Priority Group

_ 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. _____

_____

- € 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** _____