

Child's Name: _____ Date of Birth: _____ Grade: _____

****DO NOT WRITE BELOW THIS LINE****

ALL KIDS SCHOOL-BASED DENTAL PROGRAM DENTAL RECORD

(TO BE COMPLETED BY DENTIST)

PRIOR TREATMENT

Restorations:

Sealants:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

TREATMENT NEEDED

Restorative:

Sealants:

S	S
S	S
S	S
S	S
S	S
S	S

(Check off sealants placed today)

ORAL HYGIENE STATUS: _____ Good _____ Fair _____ Poor
 PERIODONTAL STATUS: _____ Good _____ Fair _____ Poor
 MALOCCLUSION: I II III

(Circle one) ORAL HEALTH ASSESSMENT RATING & SCORE:

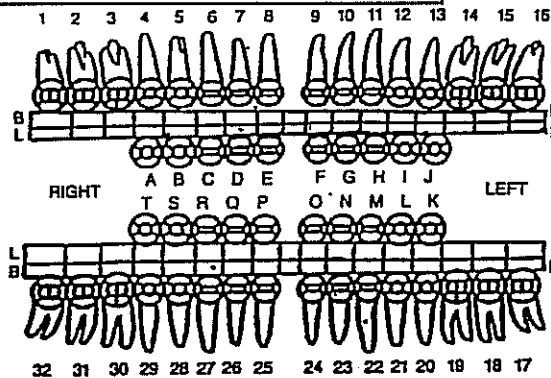
3	<u>URGENT</u> Treatment:	Abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection or swelling.
2	<u>RESTORATIVE</u> Care:	Amalgams (fillings), composites, crowns, etc.
1	<u>PREVENTIVE</u> Care: (services rendered today)	There is no visual evidence of caries activity or periodontal pathology.



TREATMENT COMPLETED TODAY:

Number of sealants placed today: _____
 Treatment Date: _____

Dentist's Signature: _____
 Hygienist's Initials: _____



NOTES:

BLUE=existing restorations; RED=treatment needed (Revised 05/11)