Dental Record

Child's Name:							Gender: M F DOB:				
Parent/Guardian's Name:							Phone #:				
1. Oral Condition before Treatment											
			Missing 🕱	Decayed 📵		Filled	۱				
			(Indicate restorations)	you performed in Item							
			Upper (G) c	DOD HO IO IO JOO 14(0) Left ingual	Lower Right		Lingual Discontinuo Continuo Cont	D) D) O Left			
2.	Tooth # or little Surfaces		Description of Work	Treatment Approved		Date Service Performed Xear		ADA Procedure Number	Actual Changes (Fee)		
3. Received: Cleaning Fluoride Treatment (restoration, pulp therapy, extraction) No problems found Other: 4. Child Oral Health Summary All planned treatment is completed? Yes No Please explain:											
Follow-up Appointment Necessary? Yes No Appt. Date: Routine recall visits Special home emphasis oral hygiene Dietary problems Developmental problem(s) Harmful oral habits Needs fluoride supplement I certify that the above services and treatments are completed.											
De	ntist/Docto	r's Signati	ure	Date							

Please return this form to MSU CDP - 330 Third St NE Mayville, ND 58257

Dental Record.HLTH.Dental 05.30.12.docx Orchid