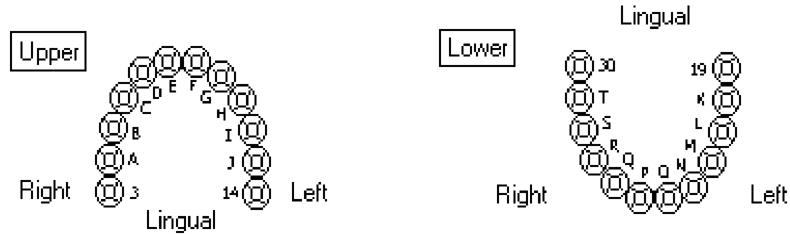
# Dental Record

**Child's Name:** ______________________ **Gender:** ☐ M ☐ F **DOB:** __________

**Parent/Guardian's Name:** ______________________ **Phone #:** __________

**1. Oral Condition before Treatment**




**2.**

| Tooth # or little | Surfaces | Description of Work | Treatment Approved | Date Service Performed | | | ADA Procedure Number | Actual Changes (Fee) | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Month | Day | Year | | | |
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**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.***

Dentist/Doctor's Signature Date

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