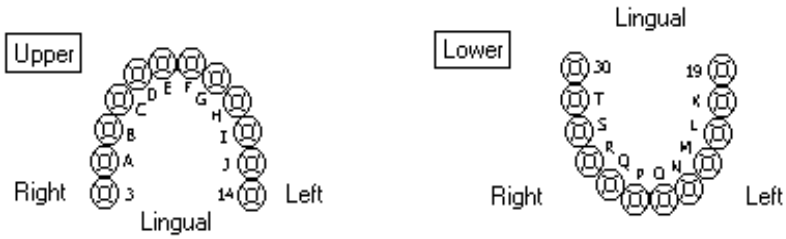
Dental Record

Child's Name	Male Female	Birth date
Parent/Guardian's Name	Phone #	

1. Oral Condition before Treatment

Missing Decayed Filled

(Indicate restorations you performed in Item #10)



2.

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

3. ☐ Treatment (restoration, pulp therapy, extraction) ☐ Cleaning ☐ Fluoride
☐ No Problem ☐ Other

4. Child Oral Health Summary

All planned treatment is completed? ☐ Yes ☐ No

Please explain

Follow-up Appointment Necessary? ☐ Yes ☐ No Date

☐ Routine recall visits ☐ Special home emphasis oral hygiene ☐ Dietary problems

☐ Developmental problem(s) ☐ Harmful oral habits ☐ Needs fluoride supplement

I certify 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