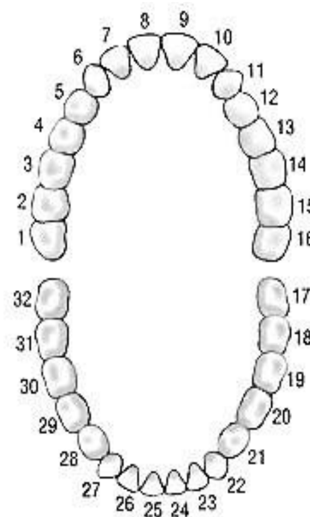
Madison South Preschool

700 S. Illinois Avenue, Mansfield, Ohio 44907
FAX NUMBER: (419) 526-2911 ATTN: Madison South Preschool

Child's Name (print or type)	**Date of Birth**
Parent's Name	**Preschool: Madison South Preschool**

Is the child now receiving any of the following?

(If yes, include length of time receiving fluoride)
Topical fluoride application: ___ No ___ Unknown ___ Yes ______________
Fluoridated water: ___ No ___ Unknown ___ Yes ______________
Fluoride supplement diet: ___ No ___ Unknown ___ Yes ______________
_____ Tablets _____ Liquid
Does the child have any trouble with teeth, gums or mouth? ___Yes ___No
If so, what kind? ___________________________________
Has the child previously seen a dentist? ____Yes ____ No
Dentist Name ________________________ Date of last visit ________________
Is child under physician's care? ____ Yes ____ No
Physician Name ____
Is child receiving medication? ____ Yes ____ No



Services provided this visit:

Tooth Number Description of work
_____________ ________________________________
_____________ ________________________________
_____________ ________________________________

Is follow-up required? ___Yes ___ No (If yes, see section below)

Name Of Dentist	**Telephone Number ( )**
Street Address	
Dentist Signature	**Date Signed**

PLEASE COMPLETE THIS SECTION FOR FOLLOW-UP REQUIREMENTS:

Please provide a written summary of the following services required:

* For the relief of pain or infection
* Restoration and/or pulp therapy of decayed permanent teeth
* Extraction prophylaxis & instructions in self-care oral hygiene procedures

Recommended follow-up dental needs (check all that apply):

( ) A. Treatment (restoration, pulp therapy, extraction)
( ) B. Cleaning
( ) C. Fluoride
( ) D. Other (please specify below)

____

Approximate number of visits need to be complete care ________________________________

Has a follow-up appointment been scheduled? ___ Yes ___ No Date: _____________