Madison Early Childhood Learning Center

1035 Grace St. Mansfield, OH 44905
Fax: 419-589-6649

Child's Name (print or type)	Date of Birth
Parent's Name	Date of examination:

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? _____

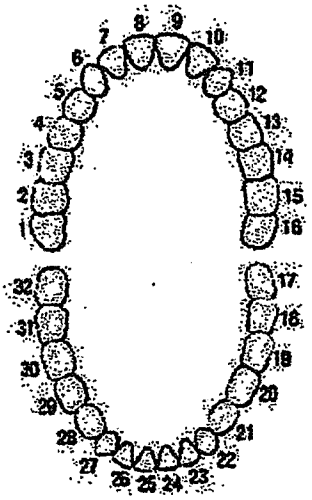
Has the child previously seen a dentist? ____Yes ____No

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: _____