



Madison Early Childhood Learning Center

1035 Grace St.
 Mansfield, Ohio 44905
 Phone: 419-589-7851
 Fax: 419-774-0557

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? _____

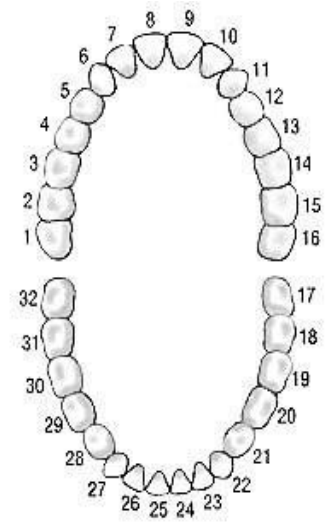
Has the child previously seen a dentist? ___ Yes ___ No

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: _____