MUSKINGUM
UNIVERSITY

Please Return Fax To: 740-826-8357
Muskingum University Center for Child Development
Attn: Sharon Price

Form To be completed by Dentist or Dental Assistant

CHILD DENTAL SCREENING

Child's Name (print or type)

Date of Birth	**Current Age**	**Parent(s) Guardian**

Is the child now receiving any of the following? If "yes" include length of time receiving fluoride.

	No	Unknown	Yes	Length of Time
Topical Fluoride application				
Fluoridated water				
Fluoride supplement diet				

Does the child have any of the following? If "yes", provide details.

	Yes	No			Yes	No
Allergies				Heat/Vascular Disease		
Asthma				Liver Disease		
Bleeding				Rheumatic Fever		
Diabetes				Sickle Cell Disease		
Epilepsy				Other(Please List)		

Does the child have any trouble with teeth, gums or mouth? _____Yes _____No
If so, what kind? _____

Is child under a physician's care? ___Yes ___No Physician's Name_____

Is child receiving medication? ___Yes ___No

Please provide a written summary of services required on the back of this form:

- For the relief of pain or infection
- Restoration and/or pulp therapy of decayed primary and permanent teeth
- Extraction of non-restorable teeth
- Dental prophylaxis and instruction in self-care oral hygiene procedures

EXAMINATION AND TREATMENT RECORD

List recommended services:

Oral Condition before Treatment:
( ) Missing ( ) Decayed ( ) Filled

Indicated restorations you perform listed below.

Priority group: _____Needs Attention Immediately
_____ Needs Attention Soon
_____ Needs Routine Care

Dental Needs: _____ Treatment (restoration, pulp therapy, extraction) _____ Cleaning
_____ Fluoride _____ No Problem _____Other:_____

Tooth # Letter	Surfaces	Description of Work	Treatment Approved	Date Services Preformed	ADA Procedure #

All planned treatment ( ) is () is not complete. If not, explain here:

The following services were provided. Explanation of each included with this report
_____ Routine recall visits _____ Special home emphasis, oral hygiene
_____ Dietary problem (s) _____ Developmental problem(s)
_____ Harmful oral habit _____ Needs fluoride supplement

Dentist Signature _____

Dentist Name (Print) _____ Date _____	Tax ID No.
Complete Address	License No. Phone