GREATER OPPORTUNITIES

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Dental Profile

Child's Name: _____ Date of Birth: ____/____/____ Center attending: _____

Exam Date:_____/_____/_____(Child's Dental History to be completed by Dentist)

EXAMINATION AND TREATMENT RECORD (List recommended services needed in order)				
Has child previously seen a dentist?	Yes / No	Date:		
Does child have any trouble with teeth or gums?	Yes / No	Date:		
Is child under physician care?	Yes / No	Date:		
Has child had fillings, crowns, extraction?	Yes / No	Date:		
Was topical fluoride applied?	Yes / No	Date:		
Is child on fluoride supplement?	Yes / No	Date:		

Treatment Needed :		
_____ YES Urgent	_____ YES, not urgent	_____ NO Problem suspected

What needs to be done?	
Treatment Scheduled Yes / No	Date Scheduled for: _____/_____/_____
All planned treatment :	_____is completed_____ is not completed

CHILD ORAL HEALTH :	Comments :
Date of Dental Exam:_____/_____/__ _____ Date of Next Appt.: _____/____/_____ Routine Recall Visit: _____ Other: _____	

Dentist Signature: _____Date: _____/_____/_____

Address:_____Phone Number:_____-_____-_____

Company:_____Fax number:_____-_____-_____