Child's Name:_____ Date of Birth:_____Grade:____

DO NOT WRITE BELOW THIS LINE

ALL KIDS SCHOOL-BASED DENTAL PROGRAM DENTAL RECORD

(TO BE COMPLETED BY DENTIST)

PRIOR TREATMENT

Restorations:	Sealants:	

TREATMENT NEEDED

Restorative:	Sealants:	
	S___	S___
	S___	S___
	S___	S___
	S___	S___
	S___	S___
	S___	S___

(Check off sealants placed today)

ORAL HYGIENE STATUS: _____Good _____Fair _____Poor

PERIODONTAL STATUS: _____Good _____Fair _____Poor

MALOCCLUSION: I II III

(Circle one) ORAL HEALTH ASSESSMENT RATING & SCORE:

3	URGENT Treatment:	5+ carious lesions, gross caries, root tips, caries likely to involve pulpal tx, abscess, soft tissue pathology, pain from disease or foreign object.
2	RESTORATIVE Care:	4 or less cavitated, occlusal, or incipient caries. Caries not close proximity to pulpal tissue.
1	PREVENTIVE Care: (services rendered today)	There is no visual evidence of caries activity or periodontal pathology.

MILES OF SMILES

TREATMENT COMPLETED TODAY *(check off)*:

_____ EXAM

_____ PROPHYLAXIS

_____ FLUORIDE TREATMENT VARNISH / GEL

_____ SEALANTS

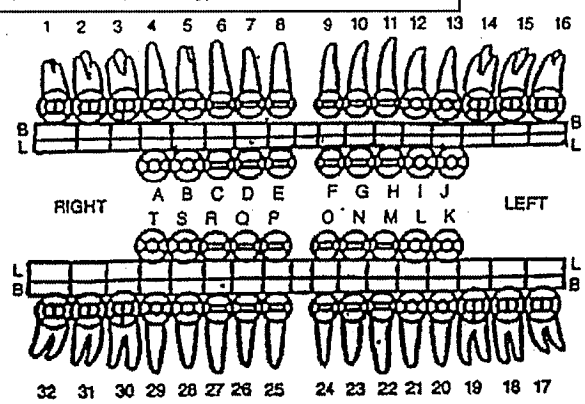
Number of sealants placed today: _____

Treatment Date: _____

Dentist's Signature: _____

Hygienist's Initials: _____

☐ NO TX ☐ Y ☐ W



NOTES:

BLUE=existing restorations; RED=treatment needed (Revised 08/14)