



Dental Checkup

Date of Service: _____

Name of Child: _____

Dentist's Name: _____

Phone Number: _____

Address: _____

Services Performed:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Dental Assessment | <input type="checkbox"/> Filling |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Crown |
| <input type="checkbox"/> Fluoride treatment | <input type="checkbox"/> Root Canal |
| <input type="checkbox"/> X-rays _____ | <input type="checkbox"/> Bridge |
| <input type="checkbox"/> Extraction | <input type="checkbox"/> Other _____ |

Overall dental assessment: _____

Currently is there any evidence of dental cavities or other repairs that need immediate care? Yes No

If "yes" what plan has been made to correct the problem? _____

Date of next appointment: _____ Phone Number: _____

Does child need or is receiving any orthodontic treatment? Yes No

Name of Orthodontist: _____ Phone Number: _____

Signature: _____

Date: _____