HACKENSACK PUBLIC SCHOOLS
EXCELLENCE IN EDUCATION

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Dental Health Record Form

Last Name:_____ First Name:_____ DOB:_____

School:_____ Gender: M F Phone:_____

Part A: To be completed by parent/guardian before dental examination

1. Is the child now receiving? If yes, length of time receiving fluoride?

a) Topical fluoride application ☐ Yes__ ☐ No ☐ Unknown
b) Fluoridated Water ☐ Yes___ ☐ No ☐ Unknown
c) Fluoride (tablets or liquid) ☐ Yes__ ☐ No ☐ Unknown

2. Has child ever been examined by a dentist? ☐ Yes ☐ No
Dentist's Name_____ Date of last visit_____

3. Is child under a physician's care? ☐ Yes ☐ No
Physician's Name_____

4. Is child receiving medication? ☐ Yes ☐ No
Name of medication _____

5. Does child have:

Allergies_____ Liver Disease _____
Asthma _____ Rheumatic Fever_____
Bleeding_____ Sickle Cell Disease_____
Diabetes _____ Heart/Vascular Disease _____
Epilepsy_____ Other: Please list _____

6. Does this child have any trouble with teeth, gums or mouth that concerns parent?

7. Source of Reimbursement or Services:

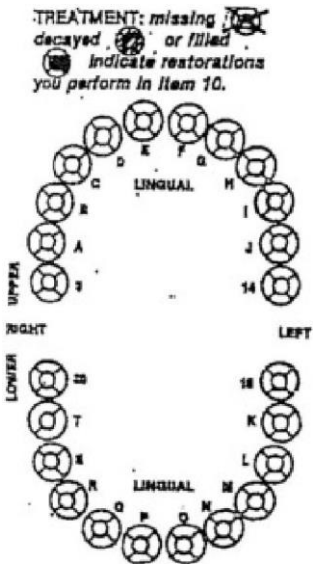
☐ Medicaid
☐ Federal, State or local agency_____
☐ Parent/Guardian
☐ Other (3rd Party) _____

8. Priority Group

☐ Needs attention immediately
☐ Needs attention soon
☐ Needs routine care

Part B: To be completed by Dentist. Examination and topical fluoride are mandatory. Prophylaxis and X-rays are optional.

9. ORAL CONDITIONS BEFORE TREATMENT **10. EXAMINATION and TREATMENT RECORD** **11. DENTAL NEEDS**



Tooth # or Letter	Description of Work	Date Service Performed MO.	DAY	YEAR
	SEE NOTES BELOW			

OFFICE STAMP

☐ No problems
☐ Cleaning
☐ Fluoride
☐ Treatment
Approximate # of Visits _____

12. CHILD ORAL HEALTH SUMMARY

All planned treatment ☐ competed
☐ not completed
☐ Routine recall visits
☐ Development problems
☐ Special home emphasis on oral hygiene
☐ Harmful oral habits
☐ Dietary problems
☐ Needs fluoride supplement

SIGNATURE: _____
DATE: _____