LICKING COUNTY EDUCATIONAL SERVICE CENTER

Evaluation & Early Education Department

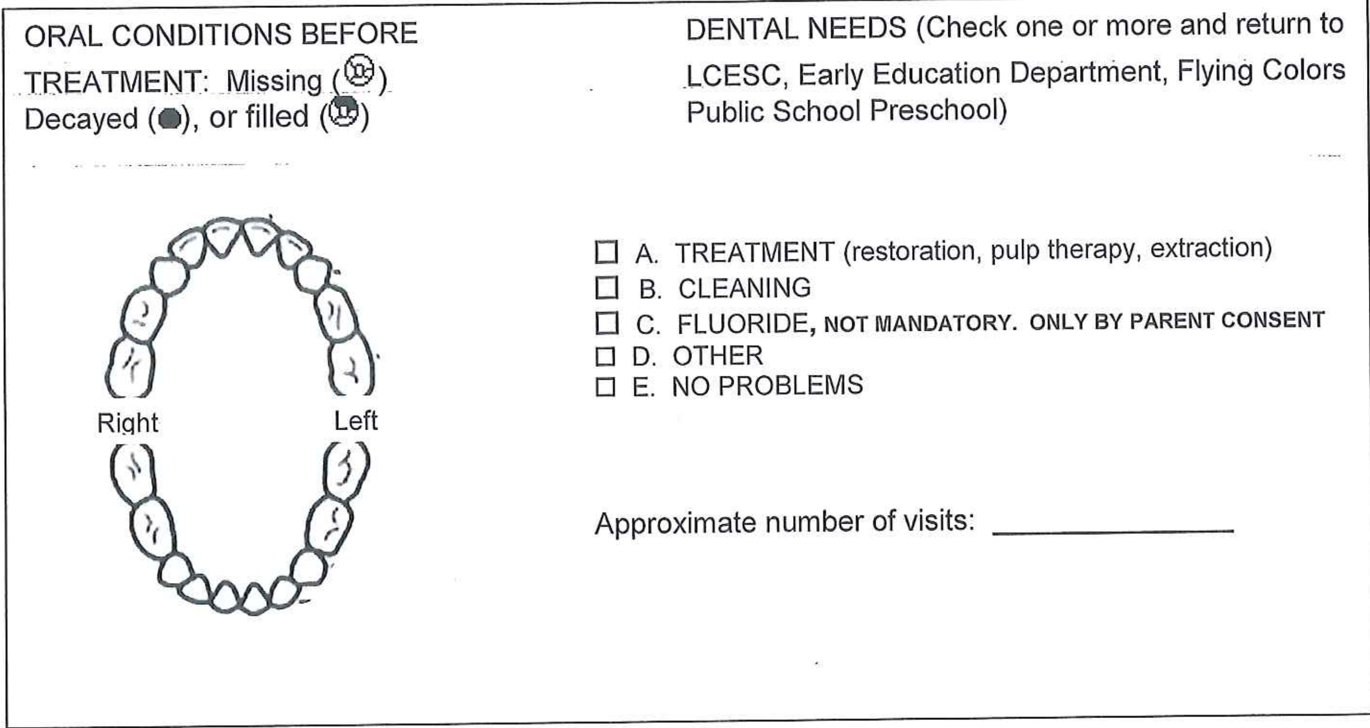
CHILD DENTAL RECORD-DENTAL SCREENING

****** Please complete all information*****

Name of Child: ______________________________ Date of Birth: _____/_____/_____

Address: ______________________________ City: ______________ Zip: __________

Home Phone: ____________________ Parent's Name(s): ______________________________



ORAL CONDITIONS BEFORE TREATMENT: Missing (⊗), Decayed (●), or filled (⊗)

DENTAL NEEDS (Check one or more and return to LCESC, Early Education Department, Flying Colors Public School Preschool)

- ☐ A. TREATMENT (restoration, pulp therapy, extraction)
- ☐ B. CLEANING
- ☐ C. FLUORIDE, NOT MANDATORY. ONLY BY PARENT CONSENT
- ☐ D. OTHER
- ☐ E. NO PROBLEMS

Approximate number of visits: ______________

CHILD ORAL HEALTH SUMMARY

All planned treatment _____ is/ _____ is not completed. If not, explain here as well as items checked:

☐ a. Routine recall visits	☐ c. Dietary problem(s)	☐ e. Harmful oral habits
☐ b. Special home emphasis, Oral hygiene	☐ d. Developmental problem	☐ f. Needs fluoride supplement

Please check here if child was unable to be examined but did appear for scheduled appointment: _____

Signature of Dentist: ______________________ Date of Examination: ______________

Flying Colors Public School Preschool
119 Union Street, Newark, OH 43055
Phone: 740-349-1629 **Fax: 740-349-1644**

For Dental Stamp with Name, Address & Phone Number

All dental exams expire 1 year from the date of examination