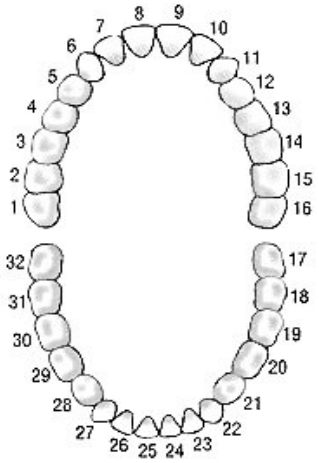
TRUMBULL COUNTY EDUCATIONAL SERVICE CENTER PRESCHOOL PROGRAM

CHILD DENTAL STATEMENT

Child's Name	Date of Birth
To be completed by the parent	
Has the child previously seen a dentist?	Yes No Unknown
if yes, Dentist's name	Date of previous exam
Does your child receive Fluoride?	Yes No Unknown
If yes, circle type Fluoride Application Fluoride Diet Supplement Fluoridated Water	
Does your child have any problems with teeth, gums, or mouth?	Yes No Unknown
If yes, please explain:	
Is your child under a Physician's care?	Yes No
If yes, Physician's name:	
Is your child receiving medication?	Yes No

To be completed by the Dentist	
Services Provided This Visit	
Tooth #	Treatment Performed
Comments	



Signature of examining Dentist Name Address : Phone:	Date of Exam

***Please provide a written summary for the following services required** * For the relief of pain or infection * Restoration and/or therapy of decayed permanent teeth * Recommended extractions	**Recommended follow-up needs** ***Please check all that apply*** ☐ Treatment (extraction, restoration) ☐ Cleaning ☐ Fluoride ☐ Other *(please explain in summary)*
Approximate number of visits to complete care?	
Has a follow-up appointment been scheduled? Yes No	**Date of follow-up appointment**