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PATIENT NUMBER

PATIENT'S NAME \_\_\_\_\_ DATE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

NICKNAME \_\_\_\_\_ AGE \_\_\_\_\_ DOCTOR \_\_\_\_\_

**MISSING TEETH - EXISTING RESTORATIONS**

RIGHT			LEFT
	A B C D E	F G H I J	
	T S R Q P	O N M L K	

**PATIENT'S CHIEF COMPLAINT:**

\_\_\_\_\_

SOFT TISSUE	REGIONAL EXAM	DISEASE CONTROL
Lips AB WNL	Head WNL	
Frenum AB WNL	Neck WNL	Calculus Y N
Palate AB WNL	Skin WNL	Plaque Lt. Hvy.
Tongue AB WNL		
Cheeks AB WNL	<b>COOPERATION</b>	Age Appropriate Cry
Ankyloglossia Y N		Cooperative
Gingiva AB WNL		Poor Cooperation

**COMMENTS:**

\_\_\_\_\_

**ORAL HABITS - QUESTIONS FOR PARENT**

Does your child take a bottle to bed at bedtime or nap time? \_\_\_\_\_

Do you brush your child's teeth? \_\_\_\_\_ What time of day? \_\_\_\_\_

Do you use toothpaste? \_\_\_\_\_ What brand? \_\_\_\_\_ How much? \_\_\_\_\_

Does your child use a pacifier? Y N

Does your child suck his/her thumb or fingers? \_\_\_\_\_

Other oral habits: \_\_\_\_\_

Was your child bottle or breast fed? \_\_\_\_\_ At what age was he/she weaned to solid foods? \_\_\_\_\_

**CONDITIONS / TREATMENTS INDICATED**

RIGHT			LEFT
	A B C D E	F G H I J	
	T S R Q P	O N M L K	

**Treatment Schedule**

Referral to pediatric dentist? \_\_\_\_\_ Dr. \_\_\_\_\_

**SIGNATURE OF DENTIST**

\_\_\_\_\_

**ANEST.**

\_\_\_\_\_

**MED. ALERT**

\_\_\_\_\_

(Under age 2 1/2)

**INFANT - TODDLER EXAMINATION**