



# Kids Central Oral Health Form

P.O. Box 661 Norton, VA 24273

www.kidscentralinc.com

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## Patient Information

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Parent's name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

This practice is the child's dental home:  Yes  No

## Current Oral Health Status

Teeth with untreated decay?  Yes  No

Previous treatment including fillings, crowns, or extractions?  Yes  No

Treatment needs?  Yes, urgent  Yes, not urgent  No treatment needs

## Oral Health Care Delivered During Visit

### Preventative Services

Examination:  Yes  No

X-Ray:  Yes  No

Cleaning:  Yes  No

Fluoride:  Yes  No

Sealants:  Yes  No

### Restorative Services

Fillings:  Yes  No

Crowns:  Yes  No

Extractions:  Yes  No

Emergency Care:  Yes  No

Other: \_\_\_\_\_

Referred to Specialty Care:  Yes  No

Treatment appointment needed?  Yes  No If yes, Date: \_\_\_\_\_ Time: \_\_\_\_\_

6 month recall (cleaning) appointment: Date: \_\_\_\_\_ Time: \_\_\_\_\_

## Oral Health Provider Contact Information

Provider Name (please print): \_\_\_\_\_

Practice Name/Address: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Phone number: \_\_\_\_\_

Date of Service: \_\_\_\_\_