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CHEROKEE NATION©

Early Childhood Unit

CHILD ORAL HEALTH RECORD

Child: _____ DOB: _____

Center: _____ Classroom: _____

Parent's Name: _____ Phone: _____

Address: _____

Do you have Sooner Care / Medicaid? Yes or No – Member ID Number: _____
Do you have Medical Insurance? Yes or No – Policy Number: _____
Company Name: _____ --Phone Number: _____
Do you have Dental Insurance? Yes or No --Policy Number: _____
Company Name: _____ -- Phone Number: _____

MUST BE COMPLETED BY PARENT:

Is the Child Now Receiving?

Topical Fluoride Application	**Yes ____**	**No ____**
Fluoridated Water	**Yes ____**	**No ____**
Fluoride Supplement Diet	**Yes ____**	**No ____**
(Tablets ____ Liquid ____)		

Screening: _____ Examination: _____

EXAMINATION/TREATMENT RECORD

(List recommended services in order)

Tooth # or Letter	Surfaces	Description of Work	Date Service Performed Mo.	Day	Yr.

PRIORITY

_____ 1. Extractions
_____ 2. Pulpotomy or Pulpectomy
_____ 3. Space maintainer
_____ 4. Routine treatment: □ Fillings □ Crowns
□ Recommendations: _____
_____ 5. No Treatment Needed
_____ 6. Comments _____

Dentist Signature Date

Facility Phone