SUM Child Development, Inc.

Dental Health Record

(Preschool and School-Age Child)

| Name of Child: | | | | | | |
|---|----------------------------|-------------|---------------------------------------|--------------|-------------------------------------|-----------------------------|
| Last | | First | | Middle | | |
| Patient's Address: | | | | | | |
| Birth Date: | | | Class: | | | |
| Has the child had previous dental care? | | | \ | es | No | |
| PRESE | AREA TES FILLING INT | W in | O O O O O O O O O O O O O O O O O O O | | ERTICLE LINE DICATES TO BE XTRACTED | "X" INDICATES MISSING TOOTH |
| ***Please check Date of exam | if cleaning | /fluoride c | ompleted. | Surface | Material | Description of Work |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Dental Treatment | | | | | | |
| All Treatm Comments or Rea | | | No _ | Dat | e Completed: _ | |
| HEREBY CERTIFY T | HAT THE SER | VICES LISTE | D ABOVE H | HAVE BEEN PE | RFORMED. | |
| Pentist's signature c | and office/ac | ddress | | | | |
| Dentist's license no. | | | | | | |