Morgan County Universal Pre-K/Head Start
CHILD - ORAL HEALTH

50 Myers Road
Berkeley Springs, WV 25411
Phone: 304-258-5335
Fax: 304-258-0638

Child Dental Exam

Appointment Date: ___/___/____ **Child's Name:** _____

Exam Completed By: ☐ Dentist ☐ Pediatrician

Provider Setting: ☐ Doctor/Dentist/Clinic ☐ School/Center ☐ Other: Specify _____

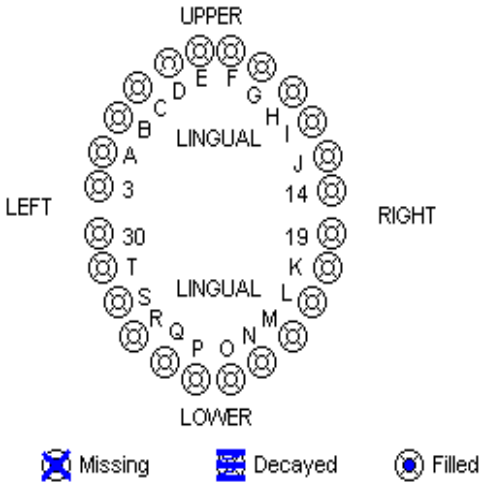
Flossing Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of Times Per Day Child Brushes Teeth: |__|__|

Uses Fluoride Toothpaste: ☐ Yes ☐ No **Takes Fluoride Supplement:** ☐ Yes ☐ No

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

General Comments on Oral Condition:

Today's Visit:	**Treatment:**	
Visual Screening Full Exam X-Rays Cleaning Fluoride Treatment Oral Hygiene Instruction Treatment (specify) _____ _____ _____ _____ _____ _____	No Treatment Needed Needs cleaning Needs oral hygiene instruction Treatment Needed **Next Appointment Date:** _____/_____/_____ Treatment Plan: _____ _____ _____ _____ _____	

Provider Signature: _____ **Completion Date:** ____/____/_____

Printed Name of Provider: _____

Address: _____ **Phone:** _____