5827 Orleans Rd.
Orleans, MI 48865
Phone: 616.754.9315
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Dental Treatment Report

Child's Name:______________________________________ Birth Date:______________________________

1. Are there any concerns regarding this child's teeth, gums, or mouth? ☐ yes ☐ no
   If yes, describe:____

2. The following services were provided on **DATE:**______________
   Dental exam ☐ yes ☐ no
   Teeth cleaned and polished ☐ yes ☐ no
   Fluoride treatment ☐ yes ☐ no

   Additional treatment provided? ☐ yes ☐ no
   If yes, describe: ______________________
   ____
   ____

3. Further treatment needed for this issue?
   ☐yes ☐ no
   If yes, describe:______________________
   ____
   Expected date(s) of completion: __________

4. Exam not completed due to:
   ☐uncooperative child
   ☐medical concern

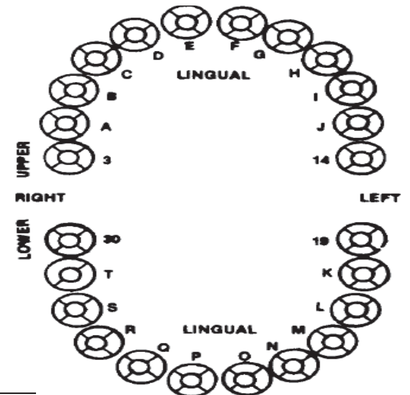
5. Referred to specialist? ☐ yes ☐ no
   Name: ___________________________
   Phone: ___________________________

6. Next appointment date: _________________

EXAMINATION AND TREATMENT RECORD
(List treatment completed)

Tooth # or letter	Surfaces	Date of services	Description of services

Oral conditions before treatment:



Dentist: _________________________________ Phone: _______________________

Address:_________________________ City:___________________ Zip:__________

Signature:____ Date:____________

Updated 2020