# Pediatric Dental CARE

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Today's Date:_____ Referred to: **Pediatric Dental Care**

Patient's Legal Name: _____
Date of Birth:_____ ❑ Male ❑ Female
Special Health Care Needs: ❑ No ❑ Yes _____
Parent/Legal Guardian:_____
Home Phone:_____ Work Phone:_____

**Last Examination:**_____ Planned treatment: ❑ Completed ❑ Deferred
Oral hygiene: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Caries history: ❑ None ❑ Low ❑ Moderate ❑ High

**Remarkable clinical findings:**
- ❑ Caries
- ❑ Developmental anomalies
- ❑ Nonnutritive habits
- ❑ Maloclusion/ Space management
- ❑ Traumatic injury
- ❑ Other_____

**Radiographic history/date**
- ❑ Bitewings _____
- ❑ Panoramic _____
- ❑ Full mouth _____
- ❑ Single tooth _____
- ❑ Cephalogram _____
- ❑ Other _____

Comments _____
_____
_____
_____

**Radiographs enclosed:** ❑ Yes ❑ No

**Behavior:** ❑ Cooperative ❑ Previous Difficulties ❑ Ongoing considerations
Comments _____

**Follow-up care to be provided by:** ❑ Pediatric Dental Care ❑ Referring Dentist

_____ _____
**Print Doctor's Name** **Referring Doctor's Signature**