Record Transfer

To: ______________________________
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Date: ______________________

Re: **Patient:** ___________________________________ DOB: ___________ ❑ Male ❑ Female

Parent/Legal guardian: ____

Special health care needs: ❑ No ❑ Yes ____

First encounter: _____________ **Chief complaint:** ________________________________

Last examination: _____________ **Planned treatment:** ❑ Completed ❑ Deferred ❑ Ongoing

Oral hygiene: ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Non-existent

Caries history: ❑ None ❑ Low ❑ Moderate ❑ High

Remarkable clinical findings:

- ❑ Developmental anomalies
- ❑ Fluorosis
- ❑ Nonnutritive habits
- ❑ Malocclusion
- ❑ Traumatic injury
- ❑ Other ____________________

Radiographic history/date:

- ❑ Bitewings ______________________
- ❑ Panoramic ______________________
- ❑ Full mouth ______________________
- ❑ Single tooth ______________________
- ❑ Cephalogram ______________________
- ❑ Other ______________________

Comments ____
____

Professional preventive care:

- ❑ Fluoride (last tx _____________)
- ❑ Sealants ___________________
- ❑ Prescription fluoride/chlorhexidine
- ❑ Dietary counseling

Management of developing occlusion:

- ❑ Monitored eruption/growth
- ❑ Appliances ______________________
- ❑ Retention ______________________
- ❑ Treatment completed ______________

Comments ____
____

Behavior: ❑ Cooperative ❑ Previous difficulties ❑ Ongoing considerations

Adjunctive techniques: ❑ Nitrous ❑ Sedation ❑ GA ❑ Other _______________

Referral for specialty care: ❑ No ❑ Yes ____

Additional considerations: ____
____

Patient due for recall: ______________

For additional information, please contact (_______) __________________

____________________________________ Signature of person completing form

____________________________________ Signature of attending dentist