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: ____

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Patient due for recall: __________

For additional information, please contact (______) ______________.

_________________________________ Signature of person completing form

_________________________________ Signature of attending dentist