

Record Transfer

To: _____

Date: _____

Re: **Patient:** _____ **Nickname:** _____

DOB: _____ Gender: _____

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
- Soft tissue pathology
- Fluorosis
- Nonnutritive habits
- Malocclusion
- Traumatic injury
- Other _____

Radiographic history/date:

- Bitewings _____
- Panoramic _____
- Full mouth _____
- Single tooth _____
- Cephalogram _____
- Other _____

Comments _____

Professional preventive care:

- Fluoride (last treatment _____)
- 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 General anesthesia Other _____

Referral for specialty care: No Yes _____

Additional considerations: _____

Patient due for recall: _____ **Recall frequency:** _____

For additional information, please contact (_____) _____

 Signature of person completing form

 Signature of attending dentist