Record Transfer

To: _____ Date: _____

_____

_____

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

Date of birth: _____ 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

Remarkable clinical findings:

- ❑ Developmental anomalies
- ❑ Soft tissue pathology
- ❑ Fluorosis
- ❑ Caries (❑ noncavitated ❑ cavitated)
- ❑ Malocclusion
- ❑ Traumatic injury
- ❑ Other (eg, habits) _____

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 _____

_____

History of caries: ❑ None ❑ Minimal ❑ Moderate ❑ Severe

Therapeutic/surgical interventions: ❑ Silver diammine fluoride ❑ Resin infiltration ❑ Pulp therapy

❑ Interim therapeutic restoration ❑ Other restoration (❑ resin ❑ amalgam ❑ crown ❑ _____)

❑ Extraction ❑ Other _____

Comments _____

_____

History of trauma: ❑ No ❑ Yes (date:_____) Comments _____

_____

Behavior: ❑ Cooperative ❑ Previous difficulties ❑ Ongoing considerations

Adjunctive techniques: ❑ Nitrous oxide ❑ Sedation ❑ General anesthesia ❑ Other _____

Referral for specialty care: ❑ No ❑ Yes _____

Additional considerations: _____

_____

Assessed caries risk: ❑ Low ❑ Moderate ❑ High **Assessed periodontal risk:** ❑ Low ❑ Moderate ❑ High

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

For additional information, please contact: (_____) _____ Email: _____

_____ _____

Printed name of pediatric dentist Signature