FAMILY ARK

101 Noah's Lane
Jeffersonville, IN 47130
812-282-8479

Record of Dental Treatment

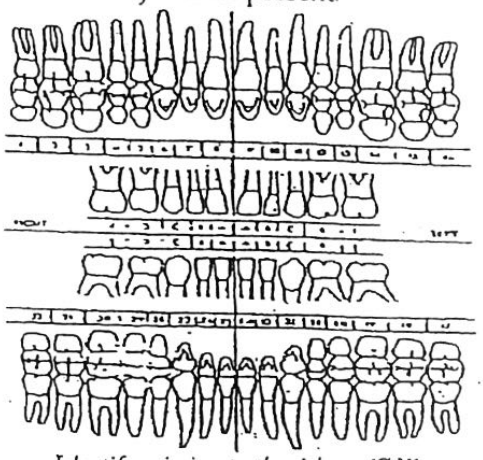
Date of treatment:_____/_____/_____

Name of Child: _____ Male / Female
First MI Last

Referral Source: _____ Foster Family: _____

DOB: ____/____/____ Medicaid/Ins. #: _____

Mark any carries present:



Identify missing teeth with an "X"

Date Completed: _____

Carries present or treatment needed:

1)

2)

3)

4)

5)

6)

Please check the appropriate box

Oral Hygiene	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Gums	☐ Healthy	☐ Fair	☐ Poor	

Treatment Administered: _____

_____

_____

Further Recommendations: _____

_____

_____

Dentist Signature: _____ Date:_____

Printed Dentist Name: _____ Tele. # _____

Dentist Address: _____ City: _____

State: _____ ZIP: _____