

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services
DENTAL CARE

CHILD'S NAME: _____ DOB: _____

DATE OF EXAMINATION: _____

GENERAL APPEARANCE OF TEETH AND MOUTH: _____

M: (missing) X: (extraction indicated)
BLUE color represents restoration present
RED color represents restoration needed

	1 2 3 4 5 6 7 8		9 10 11 12 13 14 15 16	
UPPER		PERMANENT		BUCCAL
				LINGUAL
RIGHT	A B C D E 		F G H I J 	LEFT
	(DISTAL)	DECIDUOUS	(MESIAL)	TEETH (DISTAL)
	T S R Q P		O N M L K	
LOWER		TEETH		LINGUAL
	32 31 30 29 28 27 26 25		24 23 22 21 20 19 18 17	BUCCAL

DOES CHILD NEED FOLLOW-UP APPOINTMENT? YES _____ NO _____

WHY? _____

DATE OF CHILD'S NEXT APPOINTMENT: _____

DENTIST'S SIGNATURE _____

ADDRESS: _____

PHONE _____