THE CENTER OF DENTAL PROFESSIONALS

record transfer

TO: _____

_____

_____

RE: _____

PATIENT M / F

DATE OF BIRTH / / SPECIAL HEALTHCARE NEEDS ☐ YES ☐ NO

LEGAL GUARDIAN _____

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	RADIOGRAPH HISTORY/DATE	PROFESSIONAL PREVENTIVE CARE	MANAGEMENT OF DEVELOPING OCCLUSION
☐ DEVELOPMENTAL ANOMALIES	☐ BITEWINGS _____	☐ FLUORIDE (LAST TX _____)	☐ MONITORED ERUPTION/GROWTH
☐ FLUOROSIS	☐ PANORAMIC _____	☐ SEALANTS (_____)	☐ APPLIANCES (_____)
☐ NON-NUTRITIVE HABITS	☐ FULL MOUTH _____	☐ PRESCRIPTION FLUORIDE/CHLORHEXIDINE	☐ RETENTION (_____)
☐ MALOCCLUSION	☐ CEPHALOGRAM _____	☐ DIETARY COUNSELING	☐ TREATMENT COMPLETED (_____)
☐ TRAUMATIC INJURY	☐ OTHER _____		
☐ OTHER _____			

COMMENTS

_____

_____

_____

_____

BEHAVIOR: ☐ COOPERATIVE ☐ PREVIOUS DIFFICULTIES ☐ ONGOING CONSIDERATIONS NOTES:

ADJUNCTIVE TECHNIQUES: ☐ ADJUNCTIVE TECHNIQUES ☐ NITROUS ☐ SEDATION ☐ GA ☐ OTHER:

ADDITIONAL CONSIDERATIONS:

_____

PATIENT DUE FOR RECALL:

FOR ADDITIONAL INFORMATION PLEASE CONTACT 801.747.8000

_____

SIGNATURE OF PERSON COMPLETING FORM SIGNATURE OF ATTENDING DENTIST