

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 _____