

Record Transfer



To: _____

Date: _____

Re: Patient: _____ DOB: _____ ☐ Male ☐ Female
 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
 Caries history: ☐ None ☐ Low ☐ Moderate ☐ High

Remarkable clinical findings:

- ☐ Developmental anomalies
- ☐ Fluorosis
- ☐ Nonnutritive habits
- ☐ Malocclusion
- ☐ Traumatic injury
- ☐ Other _____

Radiographic history/date:

- ☐ Bitewings _____
- ☐ Panoramic _____
- ☐ Full mouth _____
- ☐ Single tooth _____
- ☐ Cephalogram _____
- ☐ Other _____

Comments _____

Professional preventive care:

- ☐ Fluoride (last tx _____)
- ☐ Sealants _____
- ☐ Prescription fluoride/chlorhexidine
- ☐ Dietary counseling

Management of developing occlusion:

- ☐ Monitored eruption/growth
- ☐ Appliances _____
- ☐ Retention _____
- ☐ Treatment completed _____

Comments _____

Behavior: ☐ Cooperative ☐ Previous difficulties ☐ Ongoing considerations

Adjunctive techniques: ☐ Nitrous ☐ Sedation ☐ GA ☐ Other _____

Referral for specialty care: ☐ No ☐ Yes _____

Additional considerations: _____

Patient due for recall: _____

For additional information, please contact (_____) _____.

Signature of person completing form _____

Signature of attending dentist _____

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