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