

Record Transfer

To: _____

Date: _____

Re: Patient: _____ Nickname: _____

DOB: _____ Gender: _____

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

Remarkable clinical findings:

- Developmental anomalies
- Soft tissue pathology
- Fluorosis
- Caries (noncavitated cavitated)
- Malocclusion
- Traumatic injury
- Other (e.g., habits) _____

Radiographic history/date:

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

Comments _____

Professional preventive care:

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

Management of developing occlusion:

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

Comments _____

History of caries: None Minimal Moderate Severe

Therapeutic/surgical interventions: Silver diamine fluoride Resin infiltration Pulp therapy

- Interim therapeutic restoration Other restoration (resin amalgam crown _____)
- Extraction Other _____

Comments _____

History of trauma: No Yes (date: _____) Comments _____

Behavior: Cooperative Previous difficulties Ongoing considerations

Adjunctive techniques: Nitrous oxide Sedation General anesthesia Other _____

Referral for specialty care: No Yes _____

Additional considerations: _____

Assessed caries risk: Low Moderate High Assessed periodontal risk: Low Moderate High

Recall frequency: _____ Patient due for recall: _____

For additional information, please contact (_____) _____

Signature of person completing form

Signature of attending dentist