Child Dental Form

Child information:

Name: _____ Date of Birth: _____ (mm/dd/yyyy)

Sex:_____ (M/F) County: _____ Zip code: _____ Grade: _____

Race:

- ☐ American Indian /Alaska Native
- ☐ Asian
- ☐ Black/ African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ Multi-Racial
- ☐ Unknown

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic

Current Oral Health Status:

Untreated Caries: _____ (Y / N) Treated Decay: _____ (Y / N)

Sealants on Primary Molars: _____ (Y / N) Sealants on Permanent Molars: _____ (Y / N)

Urgency of Dental Care (check one): ☐ None ☐ Early ☐ Urgent

Findings and Treatment Recommendations:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Provider's Signature Date:

Mississippi State Department of Health