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CONTINUED CARE: RECALL UPDATE

Patient Name _____

DENTAL & HEALTH HISTORY UPDATE

1. Has your child received any medical care since his or her last dental appointment? Yes / No If, yes give details _____
2. Has your child seen a dental specialist? Yes / No - ortho endo oral surgeon other _____
3. Has there been a change in your child's health status? Yes / No If yes, give details _____
4. Has there been a change in your child's medications(s)? Yes / No If yes, give details _____
5. Is your child using any fluoride mouthwash? Yes / No - ACT Just for Kids Clinpro
6. Has your child sustained a traumatic dental injury since their last visit? Yes / No If yes, give details _____
7. Do you have any concerns about your child's dental health? Yes / No If yes, give details _____
8. Does your child brush their teeth three or more times per day? Yes / No
9. Do you help your child with brushing and/or check their brushing? Yes / No
10. Does your child floss every night? Yes / No
11. Does your child snack between meals? Yes / No
12. Change to insurance? Yes / No If yes, updated information _____
13. Home Phone Number: _____ Cell/Work Phone Number: _____
14. Changes to address? Yes / No Mom's Address _____
Dad's Address _____
15. Email address _____ Would you like to be contacted via email text phone

My signature below indicates that I understand and have answered all questions on the medical and dental history update to the best of my knowledge. I request and freely consent to the performance of any dental procedures for a complete dental examination, which are deemed necessary to update my child's dental status.

Signature of parent or guardian _____ Date _____

Doctor's signature _____ Date _____

FINDINGS

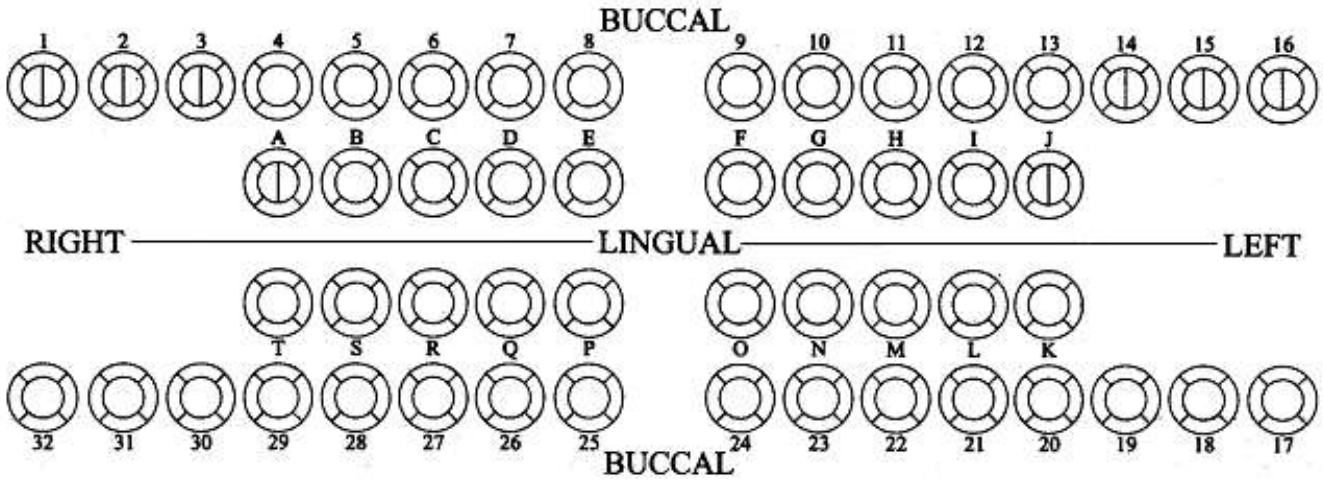
Per Patient: Brushing: _____ Flossing: Daily No Sometimes

OB _____ %	OJ _____ mm	Open bite _____ mm	Anterior crossbite	Posterior crossbite
Occlusion	CL I		CL II	CL III
Max Adequate spacing	Max Crowded	Man Adequate spacing	Man Crowded	
Oral Hygiene	Good	Fair	Poor	
Plaque	Heavy Ant. Post.	Moderate Ant. Post.	Light Ant. Post.	
Tartar	Yes No Anterior	Lingual Facial Posterior	Buccal Interproximal	
Gingivitis	Mild loc/gen Ant. Post.	Moderate loc/gen Ant. Post.	Severe loc/gen Ant. Post.	
Decay	Present	Monitor - small cavity(ies)	Watching	None
Ortho	Needs Not Yet	Phase I Phase II	Braces On Expanders In	Completed
Caries Risk Assessment	High	Moderate	Low	
Intra Oral Findings	WNL M. L. Deviation _____ <input type="checkbox"/> Ectopic Attrition _____ <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Missing teeth <input type="checkbox"/> Loose teeth			Enamel Hypoplasia <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Extra Oral Findings	WNL <input type="checkbox"/> Mouth Breather <input type="checkbox"/> Dry Lips <input type="checkbox"/> Diastema Tooth _____ mm			Nail Biting Thumbsucking

Seals Needed/OK _____ Restorative _____ Erupting 3 - 14 - 19 - 30
 2 - 15 - 18 - 31

Primary teeth: Top _____ Bottom _____ Mixed Dentition Permanent Teeth: Top _____ Bottom _____

Patient Behavior: _____



Appt No.	Tooth No.	Surface	Procedure No.	Proposed Dental Treatment Plan	Estimated Fee	Date

I have been explained and agree with the proposed treatment plan. Alternative methods of treatment and the consequences of no treatment have also been explained. I freely consent to the procedures involved in the treatment, as indicted on my child’s chart. Changes in this treatment plan will be discussed with me for my approval. My signature below indicates that I have read and accepted for my child the above and that the estimated fees have been explained to me. I agree to pay for these services at the current posted fees as they are rendered.

Date: _____ Signature of Parent, Guardian or Personal Representative _____

Oral Hygiene Reviewed

Prophy by _____ Tx entered by _____