The Birth of the First Appointment: Infant Dental Care

Medical/Dental Collaboration
Responsibility

Until he’s two or three, his dental health is your responsibility.

Dental authorities agree that a child who drinks water deficient in fluoride content needs a daily intake of a sodium fluoride supplement to help prevent caries—from infancy to age fourteen. But since most children do not visit a dentist until they are at least two or three, it’s up to you to prescribe a supplement if your community water is deficient.

Fluoride and fluoride combinations are not accepted by dental authorities because the proportions of ingredients are fixed. Such combinations make it difficult to compensate for variations in fluoride deficiency without altering the dosage of the prescribed supplement.

LURIDE brand of standardized sodium fluoride supplements are accepted by the American Dental Association. They’re as effective as fluoridated water in preventing caries when used on a consistent and continuous basis. And just as safe, too.

If the water in your community contains suboptimal amounts of fluoride (less than 0.7 ppm F), consider prescribing good-tasting LURIDE Drops and Lozi-Tabs for your younger patients. What you do now to prevent caries can play a major role in a child’s future dental health.

If you are not sure of the fluoride content of your patient’s drinking water, mail us your letterhead with the word “Luride” written on it. We’ll send you a simple form that lets us find out for you.

LURIDE Drops and Lozi-Tabs Tablets
(standardized sodium fluoride)

Continued...

You can’t rely on his pediatrician to prescribe a fluoride supplement.

Clinical studies have shown that consistent daily intake of sodium fluoride supplements is as effective as fluoridated water in preventing caries.

But you can’t rely on your pediatrician to prescribe adequate fluoride supplements. Most have only a basic knowledge of dental health. The pediatricians who do prescribe supplements for their younger patients usually choose vitamin fluoridation. They probably are not aware that dental authorities do not accept combination supplements.

Luride sodium fluoride supplements are accepted by the American Dental Association. Good-tasting Luride can help reduce caries up to 80%. And Luride’s topical uptake has also been demonstrated.

LURIDE Drops and Lozi-Tabs Tablets
(standardized sodium fluoride)

If your patient needs a fluoride supplement, it’s up to you to prescribe one. When you do, consider recommending Luride—the fluoride supplement most often prescribed by dentists.

Any water containing less than 0.7 ppm F is suboptimal. If you are not sure of the fluoride content of your patients’ drinking water, mail us the coupon below. We’ll send you a simple form that lets us find out for you.

LURIDE Drops and Lozi-Tabs Tablets
Scientific/Academic Persons or Events

Professional/Governmental Events
W.D. Miller
Microorganisms of the Human Mouth
(1890)
SAVE THOSE BABY TEETH

Baby’s Teeth Are Priceless

EVERY HEALTHY BABY should have clean teeth that are strong and sound. A clean mouth makes baby feel happy, and sound teeth are needed to chew the food that will make him grow from day to day.

Baby Teeth Must Not Be Neglected
G.V. Black
A Work on Operative Dentistry (7th ed.) (1937)
Scientific/Academic Persons or Events

- W.D. Miller: Microorganisms of the Human Mouth (1890)
- F.S. McKay: "Colorado Brown Stain" (1901)
- M.E. Jordon: Operative Dentistry for Children (1927)
- R.C. Willett: Care of the Baby's Teeth (1929)
- G.V. Black: A Work on Operative Dentistry (7th ed.) (1937)
- R.M. Stephan: The Stephan Curve (1940)
- Community Water Fluoridation (1940)
- V.D. Cheyne: Dental Care from Birth - 2 yrs (1947)
- R.J. Fitsgerald, P.H. Keyes: (1960)

Professional/Governmental Events

- (1859) American Dental Association
- (1912) Children's Bureau (now MCHB/HRSA)
- (1927) American Society of Dentistry for Children
- (1930) American Academy of Pediatrics
- (1948) American Academy of Pedodontics
- (1948) National Institute of Dental Research
American Academy of Pedodontics
(1948)

Professional/Governmental Events
Scientific/Academic Persons or Events

- **W.D. Miller**
  - Microorganisms of the Human Mouth
  - *(1890)*

- **F.S. McKay**
  - “Colorado Brown Stain”
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- **National Institute of Dental Research**
  - *(1948)*
SMOKING and HEALTH

REPORT OF THE ADVISORY COMMITTEE TO THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE

US DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service
Comparative Cost and Time Analysis Over A Two-Year Period for Children Whose Initial Dental Experience Occurs Between the Ages of Four and Eight

JOHN D. DOYKOS, III, D.M.D., M.S.D.
### Standards of Child Health Care in School Health (AAPeds) (1967)

<table>
<thead>
<tr>
<th>Age</th>
<th>History</th>
<th>Measurements</th>
<th>Physical Exam</th>
<th>Developmental Landmarks</th>
<th>Discussion and Guidance</th>
<th>Procedure</th>
<th>Attending</th>
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</thead>
<tbody>
<tr>
<td>2 yr</td>
<td>Healthy eating, sleeping, elimination, toilet training, speech, current living situation, peer and social adjustment</td>
<td>Height, weight, temperature, blood pressure, hearing</td>
<td>Complete</td>
<td>Kicks a ball in front of him with foot without support, scribbles spontaneously—purposive marking of more than one stroke on paper, balances 4 blocks on top of one another, points correctly to one body part, dumps small object out of bottle after demonstration, does simple tasks in house</td>
<td>Need for peer companionship, immaturity—inability to share or take turns, care of teeth</td>
<td>Hgb. and/or Hct., Urinalysis, Tuberculin test</td>
<td>M.D. and assistant††</td>
</tr>
</tbody>
</table>

| 21/2 yr | As for 2 yr | Complete | Throws overhand after demonstration, names correctly one picture in book, e.g., cat or apple, combines 2 words meaningfully | Guidance from questionnaire answers, dental referral, perviousness and indecisiveness | M.D. and assistant or assistant†† |

| 3 yr | As for 2 yr | Complete | Jumps in place, pedals tricycle, dumps small article out of bottle without demonstration, uses plurals, washes and dries hands | Guidance from questionnaire answers, sex education, nursery schools—qualifications of a good one, obedience and discipline | As for 2 yr DTP booster | M.D. and assistant†† |
Scientific/Academic Persons or Events

- Children’s Initial visit Between Ages Four and Eight (1967)
  Harvard Bulletin

- US Surgeons Report (1964)

1960s

- "Standards of Child Health Care" in School Health (AAPeds) (1967)
- American Society for Preventive Dentistry (ASPD) (1968)

1970s

- S.mutans in infants and children (1975)
  JADA

- Nine months in utero-first tooth (1976)
  JASPD

- ASDC PSA on first dental visit (1979)
  Pediatr Dent 1:1 (AAPeds)

- First Periodicity Schedule for Preventive Services (AAPeds) (1974)
- Definition of a ‘pedodontists’ includes infants (AAPedo) (1972)

Professional/Governmental Events
GUIDELINES

ADAPTING A SIMPLE PREVENTIVE DENTAL PROGRAM FOR CHILDREN IN YOUR OFFICE

ASDC Guideline ‘Simple Preventive Dental Program for Children’ (1972)
Scientific/Academic Persons or Events

Children’s Initial visit Between Ages Four and Eight
Harvard Bulletin (1967)

US Surgeons Report (1964)

“Standards of Child Health Care” in School Health (AAPeds) (1967)

American Society for Preventive Dentistry (ASPD) (1968)

S. mutans in infants and children
JADA (1975)

ASDC Guideline ‘Simple Preventive Dental Program for Children’
Policy Statement (AAPeds) (1972)

Nine months in utero-first tooth
JASPD (1976)

ASDC PSA on first dental visit
Pediatr Dent 1:1 (AAPeds) (1979)

First Periodicity Schedule for Preventive Services (AAPeds) (1974)
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Professional/Governmental Events
Recommenations for Preventive Health Care of Children and Youth

Committee on Standards of Child Health Care

June, 1974

The Recommendations for Preventive Health Care of Children and Youth presented below reflect the changes occurring in pediatric practice at the present time. Increased emphasis on meeting the individual needs of each child rather than trying to fit everyone into a mold in the primary office. Personalized care of the older child is another emphasis. Reduction in tuberculosis testing reflects the diminishing incidence of this disease. Urinary cultures in all females rather than repeated urinalyses is made feasible by ease, inexpensive methods. Fingerprint editors may well introduce new procedures such as cholesteotomies in the very young.

The schedule has been subjected to rigorous criticism by the entire membership through mail survey and discussion at each district meeting as well as by reports of volunteers. It is hoped that the schedule may be a tool through whose more and more children will receive needed care.

The Committee on Standards of Child Health Care of the American Academy of Pediatrics has revised the “Suggested Schedule for Preventive Child Health Care.” This revision has been done for several reasons:

1. Of primary importance is the need to upgrade the health care of many children who have not received health supervision comparable with that given by practicing pediatricians.
2. It is anticipated that the health care of an increasing number of children will be paid for by some form of health insurance.
3. The implementation of health screening provisions in Medicaid Title XIX makes the answer to this question of immediate practical importance.

The Committee on Standards is concerned with the health supervision all children should receive. Recent published studies have demonstrated that some health supervision procedures need not be repeated with the frequency previously recommended and traditionally accepted.

There is concern that only these recommended procedures may be paid for by the preventive care dollar, hence, physicians are now faced by a comparable problem in hospitals where utilization committees institute days of stay when they exceed the usual norms for a specific illness. For so, this has not proved to be a major problem for practitioners because the utilization committees are composed of physicians. Physicians rather than third party insurers must determine situations in which only the suggested recommended examinations would be required and those in which more services will be needed.

The optimal number of visits or preventive procedures for all children or their parents is at present impossible to establish. Therefore, the “Recommendations for Preventive Health Care of Children and Youth” represent a guide for the care of well children who receive competent parental care, who have not manifested any important health problems, and who are growing and developing satisfactorily.

Circumstances which may indicate the need for additional visits or procedures include:

1. First-born or adopted children, or those not with natural parents;
2. Persons with a particular need for education and guidance;
3. Disadvantaged social or economic environment;
4. The presence or possibility of a familial disease (such as low birth weight, congenital defects, or familial disease);
5. Acquired illness or previously identified disease or problems.

The services which may be required for an individual child or group of children must be determined by health care providers. The recommendations are not meant to interfere with the existing pattern of physician relationships which have proved so valuable in preventive health care. The schedule may well vary at different periods of life, at times of crises, and with changing family conditions. Physicians, third party payers and the public must appreciate that the accompanying recommended schedule constitutes a guideline for health care of children and youth, and that the needs of the individual child will be met only by providing additional services as they become necessary.

Few items in the recommendations, except immunizations, have been statistically shown to affect the health of children and youth. With some procedures, the information gained could be obtained in another way, e.g., serum or blood test. The evidence that the recommendations are effective and significant may be gained by proper interpretation and clinical studies of the results of the procedures performed. The schedule may be used by physicians as an educational tool for children and their parents.

Until three long range studies are completed, the Committee on Standards emphasizes that at least the following should be completed at every health supervision visit: initial or interval history, measurements (weight and height), cranial sutures, and dermatome and record. The repetition of some items is indicated because the “risk factors” are those which are a part of any practice–the children, their caretakers, the medical care providers. By the use of the schedule, records can be kept in a logical, standardized fashion and the results of the various steps can be compared. If copies of the schedule are used as a “check list” in each child’s chart, the accomplishment of the items could be inserted in the square.

The value of routine urinalysis and urine culture for well children is controversial. The new recommendations may well be altered in the future. Recent studies have established the deleterious effects of elevated cultures on apparently healthy children, and simple and inexpensive screening methods make this procedure practical for office use. Therefore, the Committee believes cultures should be done as suggested in the revised schedule. The Committee also emphasizes that both urinalyses and urine cultures should be finely employed in children of both sexes who are ill or failing to thrive.

Developmental and physical screening is an important element of child health care, both in establishing long range relationships between family and physician and in anticipating immediate problems.

The physician has the responsibility for ensuring that the benefits which might be gained from the omission of urinalyses are compensated for in some other way, such as previous instructions or demonstration of competencies to patients in good community or school screening programs.

The number of visits suggested in these recommendations may be reduced because of the decrease in finding problems and in certain illnesses during the past few decades. The intervals are made flexible to avoid a rigid attitude toward the transition of specific age (e.g., one year); also many physicians incorporate, when feasible, a health supervision visit at the end of school vacations. The AAP might well be the sponsoring agency for such studies.

First Periodicity Schedule for Preventive Services (AAPeds) (1974)
Scientific/Academic Persons or Events

US Surgeons Report (1964)

Children’s Initial visit Between Ages Four and Eight Harvard Bulletin (1967)

“Standards of Child Health Care” in School Health (AAPeds) (1967)

American Society for Preventive Dentistry (ASPD) (1968)

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Professional/Governmental Events
Prevention of Dental Disease from Nine Months in Utero to Eruption of the First Tooth

INTRODUCTION
The application of the preventive concept to the control of dental disease can be seen as involving three components: the individual or internal factor, the environment or external factor, and thirdly, proper timing. Optimal results require attention to all three components. To minimize etiologic factors of disease in the environment and strengthen the individual against those that remain is not enough; crucial to successful prevention is timing the manipulation of internal and external factors. Evidence to this is that in reality, most preventive efforts in dentistry today do not prevent disease but rather prevent its recurrence in patients previously affected.

The ideal application of prevention would permit a disease-free individual to enter a controlled environment optimally suited to maintain disease factors remaining in that environment. Ideal timing of the preventive effort would require intervention as early as possible prior to interaction of the individual and his environment and continuation of the preventive effort after the individual enters his environment.

The purpose of this article is to discuss an appreciation of the above ideal. Prenatal and postnatal counseling for the prevention of dental disease are realistic attempts at prevention in its most ideal form. In this paper, the rationale for such programs will be presented along with methods and supporting concepts aimed at the prevention of dental caries, periodontal
AAP Agenda for Children 2007-2008

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Health Care Equity

Special Health Care Needs
- Foster Care

Oral Health

Disaster Preparedness

Mental Health

Immunizations

Obesity

Medical Home

Access

Quality

Finance

Profession of Pediatrics

Agenda for Children

(AAP)

(2006)
Is There a Medical-Dental Divide in Pediatric Health Care?
By Paul S. Casamassimo, DDS, MS

In some recent literature, much has been made of the separation of medicine and dentistry and its influence on the limitations and problems of the oral health care system. Pediatric dentists are not divided from our medical colleagues. We see ourselves as co-therapists and policy partners, living in our respective homes in the medical and dental neighborhood. Other recent literature, more embedded in fact than opinion, bears out this view. Early childhood caries appears to be declining, and children are being seen and treated.

The following points demonstrate how pediatric dentistry is lodged within pediatric medicine in the care of children that began more than a half-century ago and persists today.

Bright Futures
ORAL HEALTH Pocket Guide
THIRD EDITION

2010 to the present
2014 AAP Oral Health Guidance
2015 AAP OHRA Tool
2016 Bright Futures and Periodicity Recommendations
2017 AAPD/OHPRC- Is There a Medical-Dental Divide in Pediatric Health Care?
# Shared Responsibility

### Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contraindications and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or lesion manifests deviations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references. Refer to the text in the Guidelines on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents (www.aapd.org/media/PedG_Guidelines_FT_Periodicity.pdf) for supporting information and references.

### Recommendations for Preventive Pediatric Health Care

Bright Futures is a program of the American Academy of Pediatric Dentistry (AAPD) and Bright Futures. The AAPD also supports providers of dental health care in strengthening the oral health care delivery system for children and adolescents. The recommendations are intended to support the delivery of high-quality preventive pediatric health care, including dental health care, through the use of evidence-based guidelines. These recommendations are available at www.aapd.org/media/PedG_Guidelines_FT_Periodicity.pdf.

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### Table: Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Clinical oral examination</th>
<th>Assess oral growth and development</th>
<th>Caries-risk assessment</th>
<th>Radiographic assessment</th>
<th>Prophylaxis and topical fluoride</th>
<th>Fluoride supplementation</th>
<th>Anticipatory guidance/counseling</th>
<th>Oral hygiene counseling</th>
<th>Dietary counseling</th>
<th>Injury prevention counseling</th>
<th>Counseling for non-nutritive habits</th>
<th>Counseling for speech/language development</th>
<th>Assessment and treatment of developing malocclusion</th>
<th>Assessment for pit and fissure sealants</th>
<th>Substance abuse counseling</th>
<th>Counseling for intraoral/perio oral plaque</th>
<th>Assessment and/or removal of third molars</th>
<th>Transition to adult dental care</th>
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<td>6 TO 12 MONTHS</td>
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