DENTAL EXAMINATION RECORD

INFORMATION N THIS FORM MAY BE SHARED WITH APPROPRIATE PERSONNEL FOR HEALTH AND EDUCATIONAL PURPOSES

TO BE COMPLETED BY THE PARENT (THIS PORTION ONLY)

PUPIL'S NAME LAST FIRST MIDDLE | BIRTHDATE MONTH DAY YEAR

ADDRESS: STREET CITY ZIP CODE | TELEPHONE

NAME OF SCHOOL: | GRADE LEVEL | SEX ☐ Male ☐ Female

PARENT OR GUARDIAN: | ADDRESS

1. IS YOUR CHILD RECEIVING FLUORIDE TREATMENTS IN SCHOOL? ☐ YES ☐ NO COMMENT_____

2. DOES YOUR CHILD HAVE ANY MEDICAL PROBLEM THAT MAY COMPLICATE DENTAL TREATMENT? (i.e. ALLERGIES, DIABETES, RESPIRATORY DIFFICULTY, HISTORY OF RHUEMATIC FEVER, ETC.) ☐ YES ☐ NO EXPLAIN_____

TO BE COMPLETED BY DENTIST:

CURRENT DENTAL STATUS OF PATIENT:

☐ URGENT—(ABCESS FORMATION, NERVE EXPOSURE, ADVANCED DISEASE STATE INCLUDING HANDICAPPED INDIVIDUALS)

☐ ROUTINE DENTAL CARE NEEDED—(ALLOYS, COMPOSITES, STAINLESS STEEL CROWNS, ETC.)

☐ PREVENTENTVE DENTISTRY ONLY NEEDED—(PROPHYLAXIS, FLOURIDE TREATMENT, SEALANTS, ETC.)

☐ NO TREATMENT REQUIRED

☐ OTHER

PATHOLOGY PRESENT

HARD TISSUE ☐ YES ☐ NO DESCRIBE _____

SOFT TISSUE ☐ YES ☐ NO DESCRIBE _____

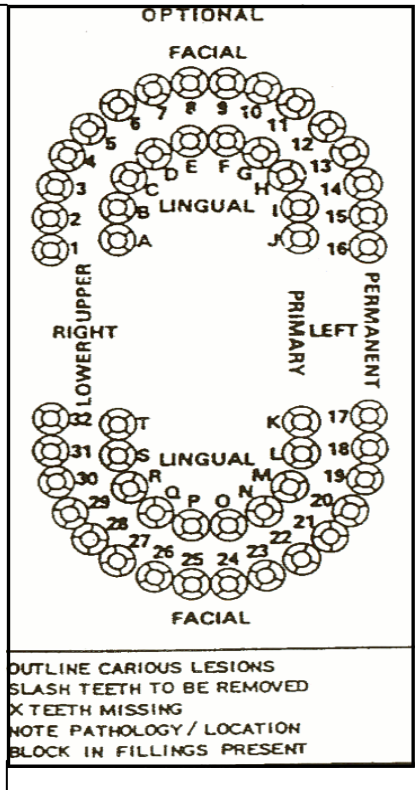
MALOCCLUSION ☐ YES ☐ NO TYPE _____

ORTHODONTIC REFERRAL RECOMMENDED ☐ YES ☐ NO

SIGNATURE OF DENTIST:_____ DATE:_____

ADDRESS:_____
STREET CITY ZIP CODE

PLEASE PRINT OR STAMP



TELEPHONE

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