Grade: _____
HR: _____

Commonwealth of Pennsylvania
Department of Health
Dental Health
Parkland School District

FAMILY DENTIST REPORT

Name of Child | Birthdate | Sex M ( ) F ( )

Home Address

The above name child last visited my office on _____ (Date).

At the time all necessary dental corrections were made. Yes ( ) No ( )

Child is currently under treatment Yes ( ) No ( )

Child has received prophylaxis Yes ( ) No ( )

With Fluoride Yes ( ) No ( )

Print Name of Dentist: _____ (D.D.S. or D.M.D.)

Signature: _____

Address: _____

Telephone: _____