Dental Examination For 2017-2018

Name of Child ______________________________ D.O.B.________ Exam Date __________

Parent or Guardian's Signature: ____

Dentist fills out all information below this space:

1. Is the child now receiving any of the following? If yes, include length of time receiving fluoride.

Topical Fluoride Application	____ No	____ Yes	____ unknown
Fluoridated Water	____ No	____ Yes	____ unknown
Fluoride Supplement diet	____ No	____ Yes	____ unknown

2. Does the child have any trouble with teeth, gums or mouth? ____No ____ Yes
3. Please provide a written summary of services required:

____ for the relief of pain or infection
____ restoration and/or pulp therapy of decayed primary and permanent teeth
____ extraction of non restorable teeth
____ dental prophylaxes & instruction in self care oral hygiene procedures

Summary (Attach additional paper if needed):

I certify that I have completed the required dental examination of the named child and will continue with any follow-up visits the family may need. (To be filled out by provider)

Dentist Name: (Print) _________________________ Date: ______________

Dentist's Signature _________________________ Phone: ______________

Address: ___________________________________

MOBILE DENTIST WILL BE AVAILABLE in the Fall

If you are interested in using this service please check appropriate space and sign on parent signature line located below child's name.

Yes, I will be using Mobile Dentist ______