Carlstadt Public School
550 Washington Street ◇ Carlstadt, NJ 07072
Phone: 201-672-3000

Dental Health Examination

CHILD'S NAME _____ Date of Birth_____ Age_____

ADDRESS_____

This dental examination form is to be completed by your dentist.

General Dental Condition _____

Recommended Dental Care_____

Signature of Examining Dentist _____Date_____

Dentist's Name (Please print/type)_____

Dentist's Address (please print/type)_____