

DENTAL EXAMINATION RECORD

INFORMATION ON 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:				BIRTH DATE		
LAST	FIRST	MIDDLE		MONTH	DAY	YEAR
ADDRESS:				TELEPHONE:		
STREET		CITY		ZIP CODE		
NAME OF SCHOOL:				GRADE LEVEL		SEX:
						<input type="checkbox"/> MALE <input type="checkbox"/> 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 RHEUMATIC FEVER, ETC.) YES NO EXPLAIN _____

TO BE COMPLETED BY DENTIST:

CURRENT DENTAL STATUS OF PATIENT:

- URGENT** - (ABSCESS FORMATION, NERVE EXPOSURE, ADVANCED DISEASE STATE INCLUDING HANDICAPPED INDIVIDUALS)
- ROUTINE DENTAL CARE NEEDED** - (ALLOYS, COMPOSITES, STAINLESS STEEL CROWNS, ETC.)
- PREVENTIVE DENTISTRY ONLY NEEDED** - (PROPHYLAXIS, FLUORIDE 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: _____

CITY ZIP CODE

OPTIONAL
FACIAL

FACIAL

OUTLINE CARIOUS LESIONS
SLASH TEETH TO BE REMOVED
X TEETH MISSING
NOTE PATHOLOGY / LOCATION
BLOCK IN FILLINGS PRESENT

TELEPHONE: _____