

Marin County Dental Society Dental Screening Form

Student's Name: _____ Grade: _____ Date: _____

Teacher: _____ School: _____ Insurance: _____

Screening Results: *This was a visual screening only. There may be dental problems present, which cannot be seen during this screening. Routine dental appointments are very important to detect and prevent damaging dental disease.*

_____ Passed- No obvious decay, but continue regular dental exams.

_____ ***Emergency**- Needs care for: _____ Infection _____ Pain _____ Gross Decay

_____ ***Needs** _____ Fillings _____ Extractions _____ Space Maintainers

_____ ***Possible areas of decay**

_____ Sealants Advised

_____ Get advice on Orthodontics (braces) at next dental visit

_____ Improve brushing and flossing

_____ Professional cleaning advised

_____ Other: _____

***Failed dental screening: REFERRAL-** The child needs a visit to a dentist as soon as possible. Please take this form to the dental visit for completion and return it to school after your child is treated. Please call the Marin County Dental Society at 472-7974 if you need a dental referral or financial assistance.

Dentist's Report to the School

Treating Dentist's Exam and Treatment:

_____ Child seen on _____. Referred to: _____

_____ Treatment is continuing. _____ MCDCF _____ UCSF _____ UOP _____ MCDS Clinic
Practitioner/Specialist

_____ Treatment is completed.

Dentist's Signature _____ Date _____ Phone# _____