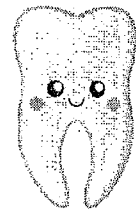






# HILLSBORO PRESCHOOL CHILD DENTAL EXAM FORM



Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Preschool Teacher: \_\_\_\_\_

Date of Dental Exam: \_\_\_\_\_

Please check the appropriate space pertaining to this child:

- Needs treatment (restoration, pulp therapy, extraction)
- No treatment need at this time
- Treatment is complete

Is this child up-to-date on scheduled age-appropriate preventative care?

- Yes
- No

Provider Name: (please print)

\_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Business Phone: \_\_\_\_\_

Signature and Credentials of Provider:

\_\_\_\_\_

Date: \_\_\_\_\_

Please return this form to: Hillsboro Preschool  
500 US 62 South, Hillsboro, OH 45133  
Fax: (937) 393-2418