SOUTH BEND COMMUNITY SCHOOL CORPORATION
737 Beale St.
South Bend, Indiana 46616
TELEPHONE: (574) 393-6000

Dental Examination Form/Formulario de examen dental

Please have your dentist complete. Please return to your student's school nurse/Por favor, haga que su dentista complete. Por favor devuélvalo a la enfermera de la escuela de su estudiante.

Student's Name:____
Date of Birth: ___/ ___/ ___
Address: ____

Dentist's Name: ____
Office Phone Number: ___________________________________
Date of exam: ____________________

Code: No Defect – 0
Defect – Note Condition

I. Teeth
Malocclusion: ____
Cavities: ____

II. Present Status
Restorations Completed: ____
Appointments Scheduled: _______________________________________

III. Orthodontic Care: ____

IV. Recommendations: ____
____

Dentist's Signature: ____ Date: ______________