BURRELL SCHOOL DISTRICT
FAMILY DENTIST REPORT

Name of child: _____ Grade: _____ Homeroom: _____

The above-named child last visited my office on: _____
(DATE)

At that time necessary dental corrections had been made: YES _____ NO _____

The child is currently under treatment: YES _____ NO _____

Please note if the child has any of the following:

- ☐ **Diseases of the supporting tissues: _____**
- ☐ **Gross malocclusion which is producing facial deformity or is interfering with function: _____**
- ☐ **Cleft palate and/or cleft lip.**
- ☐ **Other: _____**
- ☐ **Congenital malformations: _____**
- ☐ **Prosthetic replacements for lost or missing teeth: _____**

Dental Practice Name: _____

Dental Practice Address: _____

Dentist Signature: _____ D.D.S