

Grade: _____
HR: _____

Commonwealth of Pennsylvania
Department of Health
Dental Health
Parkland School District
FAMILY DENTIST REPORT

Name of Child

Birthdate

Sex M () F ()

Home Address

The above name child last visited my office on _____ (Date).

At the time all necessary dental corrections were made. Yes () No ()

Child is currently under treatment Yes () No ()

Child has received prophylaxis Yes () No ()

With Fluoride Yes () No ()

Print Name of Dentist: _____ (D.D.S. or D.M.D.)

Signature: _____

Address: _____

Telephone: _____