Otsego School District
Preschool Program
18505 Tontogany Creek Rd., Suite 4
Bowling Green, OH 43402
(419) 823-4381, option 4

CHILD DENTAL EXAM RECORD

To be completed by your Dentist

Please fax this form to: (419) 823-1703

Exam Date: _____ Child's Name: _____

Male _____ Female _____ Date of Birth: _____

Exam completed by: _____DMD _____RDH _____Other, specify _____

Evaluation Type: _____Exam _____Screening

Mouth and Structure:

Normal appearance and function? _____yes _____no
Abnormalities Noted: _____

Today's Visit Included:

____Visual Screening

____Full Exam

____X-rays

____Cleaning

____Fluoride Treatment

____Oral Hygiene Instruction

_____Treatment (describe)

Future Treatment:

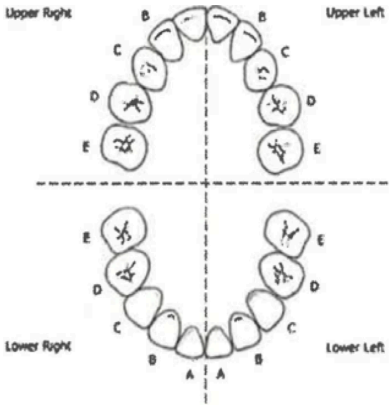
_____ No needs

_____ Treatment is Needed

Next Appointment Date:

_____

Treatment Plan:



Key: Missing Decayed Filled

Dental Professional' Signature _____

Printed or Stamped Name _____ Phone _____

Address of Provider _____