



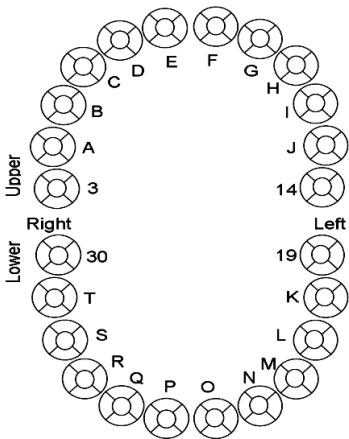
DENTAL EXAM

School: _____
Child's Name: _____ Birth Date: _____

Date of Exam: _____

- ☐ Cleaning performed
- ☐ Fluoride treatment given
- ☐ XRAY taken
- ☐ Dental Education Provided

In diagram on the left, indicate oral conditions before treatment



Please list recommended services in order on the table below & restoration performed at this visit:

Tooth # or Letter	Surfaces	Description of Services	Date of Service

CHILD ORAL HEALTH SUMMARY

Dental Needs: ☐ Routine Recall Visits ☐ Special Home Emphasis, Oral Hygiene
Problems Noted: ☐ Dietary ☐ Harmful Oral Habit(s) ☐ Developmental ☐ Other _____
All Planned Treatment: ☐ IS COMPLETE ☐ IS NOT COMPLETE*

***Please explain and check what needs to be completed:**
☐ Treatment (Restoration, Pulp Therapy, Extraction) ☐ Other: _____
☐ Number of Visits Needed: _____
☐ Treatment Referral to: _____ Phone _____

Dentist Signature _____ **Date:** _____
Dentist Printed Name: _____ **Phone** _____

Clinic Stamp:	Forward to ECE Health Team Contact:
----------------------	-------------------------------------