



Child Dental Exam

Parent/Guardian: To ensure good dental health, every child needs to have a dental exam. This checkup may be done by your own dentist. If you/your child does not have a primary dentist, please call 740-373-6669 for the names/phone numbers of local dentists taking new patients.

Child's Full Name: _____ Date of Birth: ____/____/____

School: _____ Age: _____

Dental Clinic/Dentist's Name: _____

***I authorize my dental clinic/dentist to release this document to Bright Beginnings Preschool.
(Fax: 740-376-5809)***

Parent/Guardian Signature: _____ Date: _____

To be completed by Child's Dentist

This child received the following treatment in my office:

- | | |
|---|---|
| ☐ Dental Exam | ☐ Emergency Treatment: _____ |
| ☐ X-Rays Taken | ☐ Fillings |
| ☐ X-Rays Read | ☐ Extractions |
| ☐ Cleaning | ☐ Steel Crowns |
| ☐ Topical Fluoride Application | ☐ Space Maintainers |
| ☐ Sealants | ☐ Other: _____ |

☐ **ALL TREATMENTS ARE COMPLETE.**

☐ **TREATMENTS ARE NOT COMPLETE. THE FOLLOWING IS STILL NEEDED:**

- | | |
|---|--|
| ☐ Take X-Rays | ☐ Fillings |
| ☐ Read X-Rays | ☐ Extractions |
| ☐ Sealants | ☐ Steel Crowns |
| ☐ Topical Fluoride Application | ☐ Space Maintainers |
| ☐ Other: _____ | |

I have examined this child and found he/she is in suitable condition for participation in preschool.

Signature of Dentist _____

Date of exam _____

Printed Name: _____

Address: _____

Phone: (____) _____ - _____ FAX: (____) _____ - _____