DENTAL EXAMINATION RECORD

INFORMATION ON THIS FORM MAY BE SHARED WITH APPROPRIATE PERSONNEL FOR HEALTH AND EDUCATIONAL PURPOSES.

TO BE COMPLETED BY THE PARENT: *(THIS PORTION ONLY)*

PUPIL'S NAME: LAST FIRST MIDDLE | BIRTH DATE MONTH DAY YEAR

ADDRESS: STREET CITY ZIP CODE | TELEPHONE:

NAME OF SCHOOL: | GRADE LEVEL | SEX: ☐ MALE ☐ FEMALE

PARENT OR GUARDIAN: | ADDRESS:

1. IS YOUR CHILD RECEIVING FLUORIDE TREATMENTS IN SCHOOL? ☐ YES ☐ NO COMMENT _____

2. DOES YOUR CHILD HAVE ANY MEDICAL PROBLEM THAT MAY COMPLICATE DENTAL TREATMENT? (i.e., ALLERGIES, DIABETES, RESPIRATORY DIFFICULTY, HISTORY OF RHEUMATIC FEVER, ETC.) ☐ YES ☐ NO EXPLAIN _____

TO BE COMPLETED BY DENTIST:

CURRENT DENTAL STATUS OF PATIENT:

- ☐ URGENT – (ABSCESS FORMATION, NERVE EXPOSURE, ADVANCED DISEASE STATE INCLUDING HANDICAPPED INDIVIDUALS)
- ☐ ROUTINE DENTAL CARE NEEDED – (ALLOYS, COMPOSITES, STAINLESS STEEL CROWNS, ETC.)
- ☐ PREVENTIVE DENTISTRY ONLY NEEDED – (PROPHYLAXIS, FLUORIDE TREATMENT, SEALANTS, ETC.)
- ☐ NO TREATMENT REQUIRED
- ☐ OTHER _____

PATHOLOGY PRESENT

HARD TISSUE ☐ YES ☐ NO DESCRIBE _____

SOFT TISSUE ☐ YES ☐ NO DESCRIBE _____

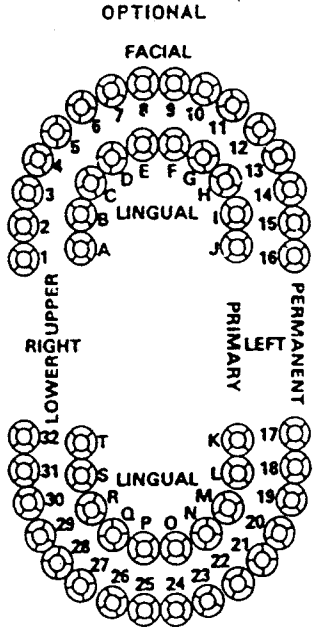
MALOCCLUSION ☐ YES ☐ NO TYPE _____

ORTHODONTIC REFERRAL RECOMMENDED ☐ YES ☐ NO

SIGNATURE OF DENTIST: _____ DATE: _____

ADDRESS: _____
STREET

OPTIONAL



OUTLINE CARIOUS LESIONS
SLASH TEETH TO BE REMOVED
X TEETH MISSING
NOTE PATHOLOGY / LOCATION
BLOCK IN FILLINGS PRESENT

TELEPHONE: