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 — (ABSCESSES 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 
CITY 
ZIP CODE 

OPTIONAL FACIAL

FACIAL

RIGHT UPPER 
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

LOWER 
21 22 23 24 25 26 27 28 29 30 31 32

PARENTAL

PERMANENT

FACIAL

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

TELEPHONE:

PLEASE PRINT OR STAMP