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 _____

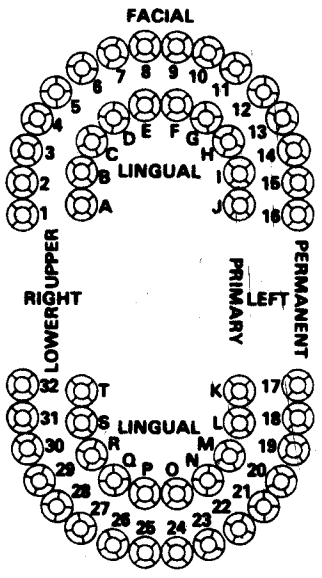
MALOCCLUSION ☐ YES ☐ NO TYPE _____

ORTHODONTIC REFERRAL RECOMMENDED ☐ YES ☐ NO

SIGNATURE OF DENTIST: _____ DATE: _____

ADDRESS: _____
STREET CITY ZIP CODE

OPTIONAL



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

TELEPHONE:

PLEASE PRINT OR STAMP