DENTAL EXAMINATION RECORD

LAST NAME	FIRST	MIDDLE	DATE OF BIRTH

PARENT/GUARDIAN ADDRESS

To the Parents/Guardians
Please arrange with your Family Dentist or clinic for your child/ward to have a dental examination and possible correction or treatment. Take this form with you and have it completed by the Dentist or Dental Nurse. Please return it to the Teacher or School Nurse.

To the Dentist or Dental Nurse
Please make an oral examination of the above named child and check "Yes" or "No" at the conditions which are so found to need dental care. Arrangements should be made for necessary correction or treatment.

The child needs professional care for the following:

Curious Teeth	Yes	No
Primary_____	____	____
Permanent_____	____	____
Periodontal Disease		
Gingivitis _____	____	____
Periodontitis_____	____	____
Occlusion_____	____	____
Fractured Dentures_____	____	____

Other_____

_____

Remarks_____

_____

Signature: _____
Dentist or Dental Nurse

Date: _____

Clinic: _____

Address: _____

Telephone: _____

School: _____

Grade: _____