Student Dental Examination

Date: _____

Student's Full Name:_____

Birthdate: _____ Age: _____ Race: _____ Sex:_____

Address: _____

Parent/Guardian: _____ Phone: _____

Please check services completed or required:

_____ Examination

_____ X-rays

_____ Prophylaxis

_____ Flouride Treatment

_____ Fillings

_____ Crown

_____ Pulp Therapy

_____ Extractions

_____ Orthodontic Treatment

_____ Bridge, plate, etc.

Status of child's dental treatment:

_____ Completed _____ In Progress _____ Not Completed

If not completed, why? _____

_____

Comments:

Signature of Examiner _____ **Date:** _____

Clinic: _____

Address: _____ **Phone:** _____