DENTAL EXAMINATION FORM

To be completed by the parent (please print)

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)
Address: Street	City	Zip	Phone Number
Parent /Guardian			Gender ☐ Male ☐ Female

To be Completed by the Dentist

Oral Health Status (circle all that apply)

Yes No Dental Sealants present

Yes No Caries Experience/Restoration History- A filling (temporary/permanent) or a tooth that is because it was extracted as a result of caries or missing permanent 1st molars.

Yes No Untreated Caries- at least 1/2mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surface. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary filings, are considered sound unless a cavitated lesion is also present.

Yes No Soft Tissue Pathology

Yes No Malocclusion

Treatment Needs (check all that apply)

____ Urgent Treatment –abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, Infection, or swelling.

____ Restorative Care-Amalgams, composites, crowns, etc.

_____ Preventive Care- sealants, fluoride treatment, prophylaxis

_____ Other-periodontal, orthodontic

Please Note:_____

_____ _____

Signature of Dentist **Date**

_____ _____

Address **Phone Number**