CENTRAL
CHRISTIAN SCHOOL

Dental Examination

Student's name _____
Birth date _____/_____/_____
Street address_____
City_____Zip_____
Dentist's Name_____Dentist's phone number_____

THE FOLLOWING TO BE FILLED OUT BY EXAMINING DENTIST:

Please Check the Appropriate Spaces:

Gingiva: Inflamed_____Normal_____Other_____

Prophylaxis and Fluoride Treatment: Date of Last_____

Caries, Deciduous Teeth: Yes_____No_____

Caries, Permanent Teeth: Yes_____No_____

Occlusion: Class I_____Class II_____Class III_____

Home Care: Good_____Poor_____

Habits detrimental to oral health: Yes_____No_____

Please specify:_____

Encircle abnormalities noticed in oral cavity:

Throat	Tongue	Lips
Abscess	Palate	Missing Teeth

Other….Please specify_____

Has the parent or guardian been informed of any abnormalities or dental problems needing attention? Yes_____No_____

Additional remarks or information which you feel might be of assistance to the school In promoting good dental health for this student: _____
_____
_____

Date:_____Examining Dentist:_____