Oakwood City School Preschool Program
Dental Exam Form

(Please return to the school once completed)

Student Name: ___________________________________DOB:_____________M:_____F:_____

Address ____
Telephone: ____

Parent/Guardian Name(s):

____

Medical and Dental History:

____
____

Current Medication(s): ____
____

TO BE COMPLETED BY DENTIST

EXAM:

- Mouth and structures
  - Normal appearance and function yes/no
  - Abnormalities noted____

Primary Dentition:

- Missing teeth yes/no Location: ______________________________
  Treatment: ____________________________
- Loose teeth yes/no Location: ______________________________
  Treatment: ____________________________
- Broken teeth yes/no Location: ______________________________
  Treatment: ______________________________
- Dental caries yes/no Location:________________________________
  Treatment: ______________________________

Permanent Dentitions:

- Missing teeth yes/no Location: _______________________________
  Treatment: ______________________________
- Loose teeth yes/no Location: ______________________________
  Treatment: ______________________________
- Broken teeth yes/no Location: ______________________________
  Treatment: ______________________________
- Dental caries yes/no Location: ______________________________
  Treatment: ____________________________

I certify that this child was examined on the date stated below.

Date of Exam **Dentist Signature**

Address and Telephone Number **Fax #**

SH Form #13 (05/14)