Preschool Dental Exam Form

(Please return to the school once completed)

Student Name:		DOB:	M:F:
elephone:			
arent/Guardian Name(s)):		
Medical and Dental Histor	ry:		
Current Medication(s):			
O BE COMPLETED BY	DENTIST		
XAM:			
Mouth and struct	ures		
		nction yes/no	
	lities noted		
rimary Dentition:			
Missing teeth	yes/no	Location:	
	, 35, 110	Treatment:	
 Loose teeth 	yes/no		
	, ,	Treatment:	
o Broken teeth	yes/no	Location:	
		Treatment:	
 Dental caries 	yes/no	Location:	
amanant Bantitian -		Treatment:	
ermanent Dentitions	yes/no	Location	
 Missing teeth 	yes/110	Location: Treatment:	
o Loose teeth	yes/no		
	, 30,	Treatment:	
o Broken teeth	yes/no		
		Treatment:	
 Dental caries 	yes/no	Location:	
		Treatment:	
certify that this child	was examined	on the date stated below.	
Pate of Exam	De	ntist Signature	
Address and Telephon	e Number		Fax #
H Form #13 (04/23)			
DENTIST			
OFFICE			
STAMP			