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)

DENTIST OFFICE STAMP