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)