

DENTAL EXAMINATION RECORD

INFORMATION ON THIS FORM MAY BE SHARED WITH APPROPRIATE PERSONNEL FOR HEALTH AND EDUCATIONAL PURPOSES

TO BE COMPLETED BY THE PARENT (THIS PORTION ONLY)

PUPIL'S NAME LAST FIRST MIDDLE			BIRTHDATE MONTH DAY YEAR		
ADDRESS: STREET CITY ZIP CODE			TELEPHONE		
NAME OF SCHOOL:		GRADE LEVEL		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
PARENT OR GUARDIAN:		ADDRESS			

1. IS YOUR CHILD RECEIVING FLUORIDE TREATMENTS IN SCHOOL? YES NO COMMENT _____

2. DOES YOUR CHILD HAVE ANY MEDICAL PROBLEM THAT MAY COMPLICATE DENTAL TREATMENT? (i.e. ALLERGIES, DIABETES, RESPIRATORY DIFFICULTY, HISTORY OF RHEUMATIC FEVER, ETC.) YES NO EXPLAIN _____

TO BE COMPLETED BY DENTIST:

CURRENT DENTAL STATUS OF PATIENT:

- URGENT—(ABSCESS FORMATION, NERVE EXPOSURE, ADVANCED DISEASE STATE INCLUDING HANDICAPPED INDIVIDUALS)
- ROUTINE DENTAL CARE NEEDED—(ALLOYS, COMPOSITES, STAINLESS STEEL CROWNS, ETC.)
- PREVENTENTVE DENTISTRY ONLY NEEDED—(PROPHYLAXIS, FLUORIDE TREATMENT, SEALANTS, ETC.)
- NO TREATMENT REQUIRED
- OTHER

PATHOLOGY PRESENT

HARD TISSUE YES NO DESCRIBE _____

SOFT TISSUE YES NO DESCRIBE _____

MALOCCLUSION YES NO TYPE _____

ORTHODONTIC REFERRAL RECOMMENDED YES NO

SIGNATURE OF DENTIST: _____ DATE: _____

ADDRESS: STREET CITY ZIP CODE

PLEASE PRINT OR STAMP

OPTIONAL

FACIAL

LINGUAL

UPPER LOWER

RIGHT LEFT

PRIMARY PERMANENT

FACIAL

**OUTLINE CARIOUS LESIONS
SLASH TEETH TO BE REMOVED
X TEETH MISSING
NOTE PATHOLOGY / LOCATION
BLOCK IN FILLINGS PRESENT**

TELEPHONE

IDPH-DEA.001 10/80 IL 482-0384