

## Dental Record

Padres: Por favor devuelva este informe firmada por el dentista a la escuela para que usted pueda completar los procedimientos de inscripción de su niño en la escuela. La inscripción no estará completa hasta que se hayan recibido todos los registros.

---

Student's legal name

---

Sex

Date of Birth

Phone Number

---

Parent or Guardian Name

---

Address (city, state, zip)

Date of last dental visit prior to this date: \_\_\_\_\_

Number of teeth present: Deciduous: \_\_\_\_\_

Permanent: \_\_\_\_\_

Number of caries: \_\_\_\_\_

Oral Hygiene: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Malocclusion \_\_\_\_\_

Missing Teeth: \_\_\_\_\_

Fractured Teeth: \_\_\_\_\_

Abscessed Teeth: \_\_\_\_\_

Anomalies \_\_\_\_\_

Habits: Tongue Thrust \_\_\_\_\_ Finger or Thumb Habit \_\_\_\_\_

Were X-rays taken? \_\_\_\_\_

Gums: Normal \_\_\_\_\_ Inflamed: \_\_\_\_\_

Was necessary work completed? \_\_\_\_\_

---

Date examined

---

Dentist's Name