Dental Record

Parents: Please return this report to the school to complete registration procedures, signed by the dentist. Registration will not be complete until all records have been received.

_____

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