FAMILY DENTIST REPORT

School District: _____ County: _____

_____ _____

Name of Child (Last, First, Middle) Birthdate

_____

Home Address (No. and Street)

Sex: _____

The above named child last visited my office on _____.
(Give date)

At that time all necessary dental corrections had been made.

YES NO

If the answer is NO, please fill in the following:

Primary Teeth _____ Fillings ____ Extractions ____

Permanent Teeth _____ Fillings ____ Extractions ____

Diseases of the supporting tissues _____

Gross Malocclusion that is producing a facial deformity or is interfering with function _____

Cleft Palate and/or Cleft Lip _____ Other Congenital Malformations _____

Prosthetic replacements for lost or missing teeth _____

This child is currently under treatment. YES ____ NO ____

Signature: _____

Date Submitted: _____ Address: _____

_____

(Return this from to the School Nurse.)