

TO BE COMPLETED BY THE PARENT.- (THIS PORTION ONLY)

PUPIL'S NAME: LAST			FIRST	MIDDLE	BIRTH DATE 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: _____

1. 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.)
- PREVENTIVE DENTISTRY ONLY NEEDED** (prophylaxis, fluoride treatment, sealants, etc.)
- NO TREATMENT REQUIRED**
- OTHER:** _____

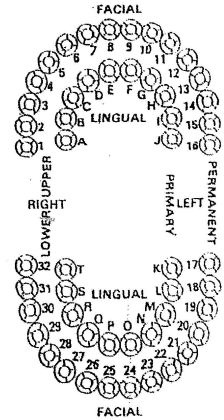
PATHOLOGY PRESENT

Hard Tissue YES NO Describe: _____

Soft Tissue YES NO Describe: _____

Malocclusion YES NO Describe: _____

OPTIONAL



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

ORTHODONTIC REFERRAL RECOMMENDED YES NO

Telephone: _____

Signature of Dentist: _____ Date: _____

Address: _____
Street City Zip Code