DENTAL EXAMINATION FORM

WHEN COMPLETED PLEASE FORWARD TO:

Vandalia-Butler City Schools - Preschool
1010 East National Road Vandalia, Ohio 45377
(937) 415-6500 Fax: (937) 415-6538

Name: _____ DOB: _____ M: ____ F: ____

Address: _____

Phone: _____

Parent/Guardian: _____

Medical/Dental History: _____

_____

Medication: _____

EXAM:

- Mouth and Structures
  - Normal appearance and function: Yes / No
  - Abnormalities noted _____
  - _____
- Primary Dentition:
  - Missing Teeth: Yes / No Loose Teeth: Yes / No
  - Broken Teeth: Yes / No
  - Dental Caries: Yes / No Location: _____ Treatment: _____
    Location: _____ Treatment: _____
- Permanent Dentition:
  - Missing Teeth: Yes / No Loose Teeth: Yes / No
  - Broken Teeth: Yes / No
  - Dental Caries: Yes / No Location: _____ Treatment: _____
    Location: _____ Treatment: _____

I certify that this child was examined on the date stated below.

_____

Date of Exam Dentist Signature

_____

Address and Telephone Number Fax #