Auglaize County Preschool

1045 Dearbaugh Avenue, Suite 2, Wapakoneta, OH 45895
Phone: (419) 738-3422 Fax: (419) 738-1267

DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name:______________________________________ Birth Date:__________
Last First Middle

Address:______________________________________ Telephone:__________
Street City State Zip Code

Name of School:____________________ Grade Level:______ Gender: ☐Male ☐Female

Parent or Guardian: ______________________________________

Parent/Guardian Address:______________________________________
Street City State Zip Code

To be completed by dentist

Oral Health Status (check all that apply)

☐Yes ☐No **Dental Sealants Present**

☐Yes ☐No **Caries Experience/Restoration History**—A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐Yes ☐No **Untreated Caries**—At least ½ mm of tooth structure loss at the enamel surface. Brown to dark brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐Yes ☐No **Soft Tissue Pathology**

☐Yes ☐No **Malocclusion**

Treatment Needs (check all that apply)

Urgent Treatment—abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

Restorative Care—amalgams, composites, crowns, etc.

Preventive Care—sealants, fluoride treatment, prophylaxis

Other—periodontal, orthodontic

Please note:______________________________________

______________________________________ ____________
Dentist Signature Date

____

____
Address & Phone

Auglaize County Preschool

1045 Dearbaugh Avenue, Suite 2, Wapakoneta, OH 45895
Phone: (419) 738-3422 Fax: (419) 738-1267

DENTAL FORM

Child's Name______________________ Sex______ D.O.B.__________

Parent/Guardian's Name______________________ Phone__________

Address______________________ Zip Code________ Center__________

Facial

DIAGNOSTIC CODE:

Solid area indicates filling present

Zebra stripes indicate decay present

Vertical line indicates to be extracted

Indicates missing tooth

If follow-up is needed, please explain the treatment plan.

Is there any indication of baby bottle tooth decays?

_____Yes _____No

1. How many restorations are needed?__________
2. How many visits will be needed to complete the follow-up?__________
3. Date of next appointment?__________

PLEASE CHECK SERVICES PROVIDED:

_____Fluoride _____Prophylaxis _____Instruction in oral hygiene
_____Restoration of decayed teeth _____ Pulp therapy
_____Extraction

PRIORITY GROUP:

____Needs Attention Immediately
____Needs Attention Soon ____Needs Routine Care

SERVICES PROVIDED: (Please record each treatment on a separate line)

Month	Day	Year	Tooth	Surface	Material	Description of Work

*Treatment code: Surfaces, M=Mesial, Distal, O=Occlusal, L=Lingual, I=Incisal, B=Buccal or Libial, A=Amalgam, S=Silicate, P=Arcylic, C=Steel Crown, O=Other

Important: _______Check if additional work required _______Check if all work for this child has been completed
_______Check if treatment discontinued: explain above

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

Date of Examination__________

Dentist Signature__________ Address__________

City__________ Zip Code__________ Phone__________

Reason for objection to completing the dental examination: __________

Name: __________ Title: __________