

Nuglaize 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 1/4 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

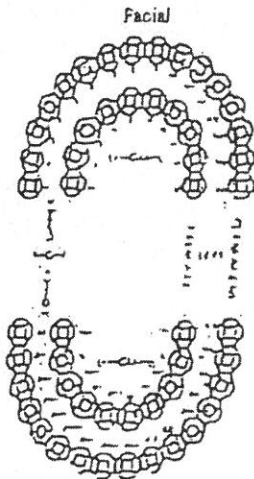
Address & Phone

Auglaize County Preschool





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DENTAL FORM

Child's Name _____ Sex _____ D.O.B. _____
 Parent/Guardian's Name _____ Phone _____
 Address _____ Zip Code _____ Center _____



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? _____

PRIORITY GROUP:

____ Needs Attention Immediately
 ____ Needs Attention Soon ____ Needs Routine Care

PLEASE CHECK SERVICES PROVIDED:

____ Fluoride _____ Prophylaxis _____ Instruction in oral hygiene
 ____ Restoration of decayed teeth _____ Pulp therapy
 ____ Extraction

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 Labial, 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: _____