communityconnections

DENTAL EXAMINATION FORM

Child's Name: ________________________________ DOB: __________

Date of appointment: ____

Purpose of appointment: ___six month cleaning & examination ___follow up

TO BE COMPLETED BY DENTAL CARE PROVIDER:

Services provided: ☐ examination ☐ cleaning ☐ fluoride treatment

☐ sealants ☐ filled cavities ☐ other ______________________________

____

Findings/recommendations: _______________________________________

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Next appointment needed by: ______________________________________

Signature of Dental Provider: _____________________________________

Print Name: ____

Address: ____

____

Phone Number: ____

Foster Parents: *A dental provider's statement with the above information provided, including the dental provider's signature, is acceptable. Please submit to your Family Consultant upon completion.*