

# DENTAL EXAMINATION



**PART 1** (COMPLETED BY PARENT OR STAFF)

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

PARENT/GUARDIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_

STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_

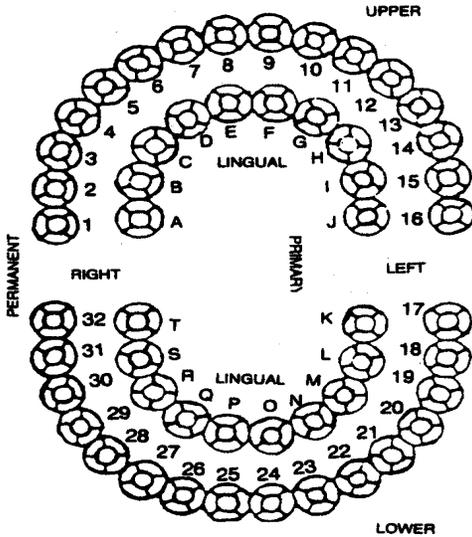
PHONE: \_\_\_\_\_

**HEALTH PROFESSIONAL PLEASE COMPLETE PART 2, 3, 4, & 5**

**PART 2**

EXAM DATE	TOOTH	SURFACE	MATERIAL	DESCRIPTION OF WORK

**PART 3**



**DIAGNOSTIC CODE**

- Solid Area Indicates Filling Present
- Zebra Stripes Indicates Decay Present
- Vertical Line Indicates To Be Extracted
- "X" Indicates Missing Tooth

**PLEASE CHECK SERVICES PROVIDED**

- \_\_\_\_\_ Fluoride
- \_\_\_\_\_ Prophylaxis
- \_\_\_\_\_ Instruction in oral hygiene
- \_\_\_\_\_ Restoration of decayed teeth
- \_\_\_\_\_ Pulp therapy
- \_\_\_\_\_ Extraction

**PART 4 - ADDITIONAL INFORMATION:**

**PART 5 - PLEASE CHECK ONE:**

\_\_\_\_\_ Work for this child has been completed and 6 months checkup is recommended.

\_\_\_\_\_ Additional work is required and noted in Part 4, additional information.

NEXT APPOINTMENT:

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

SIGNATURE OF HEALTH PROFESSIONAL

OFFICE

DATE