CAMBRIDGE PRESCHOOL

518 S 8th St
Cambridge, OH 43725

(phone) 740-439-7592
(fax) 1-800-521-6763

Child Dental Exam Form

PARENT, COMPLETE AREA IN THIS BOX THEN GIVE TO DENTIST.

Child's Name_____ Date of Birth_____

Parent's Name_____ Preschool: CAMBRIDGE PRESCHOOL

Is the child now receiving any of the following?

(If yes, include length of time receiving fluoride)

Topical fluoride application: _____ No _____ Unknown _____ Yes _____

Fluoridated water: _____ No _____ Unknown _____ Yes _____

Fluoride supplement diet: _____ No _____ Unknown _____ Yes _____

_____ Tablets _____ Liquid

Does the child have any trouble with teeth, gums or mouth? _____ Yes _____ No

If so, what kind?_____

Has the child previously seen a dentist? _____ Yes _____ No

Dentist Name _____ Date of last visit _____

Is child under physician's care? _____ Yes _____ No

Physician Name _____

Is child receiving medication? _____ Yes _____ No

Date of Exam_____ **Services provided this visit:**

Tooth Number	Description of work

Is follow-up required? _____ Yes _____ No

(If yes, see section below)

Name of Dentist	Telephone Number ( )
Street Address	City, State, Zip

Dentist Signature	Date Signed

PLEASE COMPLETE THIS SECTION FOR FOLLOW-UP REQUIREMENTS

Please provide a written summary of the following services required:

* For the relief of pain or infection
* Restoration and/or pulp therapy of decayed permanent teeth
* Extraction prophylaxis & instructions in self-care oral hygiene procedures

Recommended follow-up dental needs (check all that apply):

( ) A. Treatment (restoration, pulp therapy, extraction)
( ) B. Cleaning
( ) C. Fluoride
( ) D. Other (please specify below)

Approximate number of visits need to be complete care _____

Has a follow-up appointment been scheduled? ____ Yes ____ Date _____