

Dental Health Program
FAMILY DENTIST REPORT

Medical
 Services
 Division
 Sh3 323 Rev. 1/69

School	Grade	Room
Name of Child (Last) (First) (Middle)	Birthdate	Sex M <input type="checkbox"/> F <input type="checkbox"/>
Home Address (Number and Street)		Zip

The above named child last visited my office on(Give date). At that time all necessary dental correction has been made. Yes No

If the answer is NO – fill in the following:

Primary teeth Fillings Extractions

Permanent teeth Fillings Extractions

Diseases of the supporting tissues

Gross malocclusion which is producing a facial deformity or is interfering with function

Cleft palate and/or cleft lip Other congenital malformations

Prosthetic replacements for lost or missing teeth

This child is currently under treatment Yes No

Signature: _____ D.D.S.

Date Submitted: _____ Address: _____