

DENTAL HEALTH PROGRAM
FAMILY DENTIST REPORT

SCHOOL		GRADE	ROOM
NAME OF CHILD (LAST) (FIRST) (MIDDLE)		BIRTHDATE	SEX M <input type="checkbox"/> F <input type="checkbox"/>
HOME ADDRESS (NO. 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:

This child is in need of treatment for one or more of 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

DATE SUBMITTED

SIGNATURE _____ D.D.S.
ADDRESS _____