

ROCHESTER SCHOOL DENTAL EXAM FORM

Name: _____ Age: _____

Date: _____

Has patient received dental care previously? YES _____ NO _____

Soft Tissue Exam NORMAL _____ ABNORMAL _____

REMARKS: _____

Dentition Exam:

Caries Present YES _____ NO _____

Deciduous: OCCLUSAL _____ PERMANENT: OCCLUSAL _____
 PROXIMAL _____ PROXIMAL _____

MISSING TEETH: _____

JAW AND TEETH RELATIONSHIP: NORMAL _____ ABNORMAL _____

REMARKS: _____

OPTIONAL RADIOGRAPHIC EXAM: _____

CHILD'S DENTAL CONDITION:

ACCEPTABLE: _____

TREATMENT NEEDED: _____

TREATMENT URGENT: _____

TREATMENT:

SCHEDULED: _____

COMPLETED: _____

OTHER: _____

SIGNATURE OF DENTIST

Information obtained from this form is protected health information and HIPPA/ FERPA disclosure guidelines will be strictly followed.