Fruitport Community Schools **DATE RECEIVED AT SCHOOL**

DENTAL EXAMINATION

PART 1 (COMPLETED BY PARENT)

PATIENT NAME: **DATE OF BIRTH**

PARENT/GUARDIAN NAME:

ADDRESS: **CITY:** **STATE:** **ZIP:**

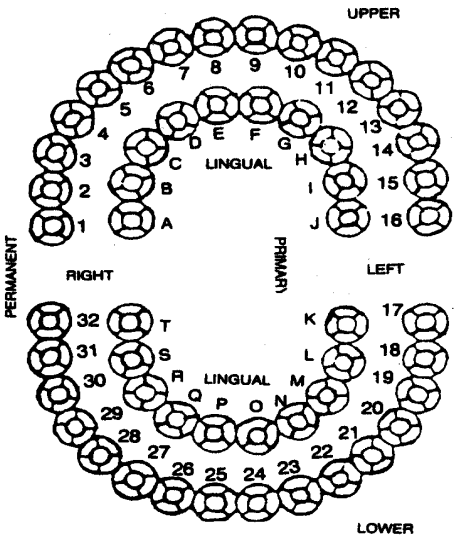
PHONE:

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

Verticle 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 inforamtion.

NEXT APPOINTMENT: **DATE:** **TIME:**

SIGNATURE OF HEALTH PROFESSIONAL **OFFICE** **DATE**