DENBIGH HIGH SCHOOL

DENTAL EXAMINATION RECORD

SCHOOL YEAR _____

GRADE: _____

LAST NAME	**FIRST**	**MIDDLE**	**DATE OF BIRTH**

PARENT/GUARDIAN **ADDRESS**

To the Parents/Guardian:

Please arrange with your family Dentist or Clinic for your child/ward to have a dental examination and possible correction or treatment. Have this form completed by the Dentist or Dental Nurse. Please return it on the day of Registration.

To the Dentist or Dental Nurse:

Please make an oral examination of the above-named child and check *"Yes" or "No"* at the conditions. We also ask that arrangements be made for necessary correction or treatment.

The child needs professional care for the following:-

Carious Teeth	**Yes**	**No**
Primary _____	_____	_____
Permanent _____	_____	_____
Periodontal Disease		
Gingivitis _____	_____	_____
Periodontitis _____	_____	_____
Occlusion _____	_____	_____
Fractured Dentures _____	_____	_____

Other _____

_____

Remarks _____

_____

Signed: _____ _____
Dentist or Dental Nurse Date

Clinic: _____

Address: _____ Tel #:_____