Preschool Dental Exam Form

Child's name:	DOB:
Parents' name:	School District:

TO BE COMPLETED BY PARENT:

1. Child (has ___, has not ___) previously seen a dentist.
   Dentist's name: _____
2. Child (is ___, is not ___) under a physician's care.
   Physician's name: _____
3. Child (is ___, is not ___) receiving medication. Type: _____
   _____
4. Does your child have any trouble with teeth, gums, or mouth that you know about?
   No ___ Yes (describe) _____

TO BE COMPLETED BY DENTIST:

1. Child Oral Health Summary:

Date	Treatment performed

2. Is baby bottle tooth decay present? Yes No
3. Is the child now receiving **Topical Fluoride** Yes No **Fluoride Supplement** Yes No
4. Recommendations for further treatment: _____
   _____
5. Comments: _____

Dentist's Signature: _____ Date: _____

Dentist's Name: _____ Phone Number: _____

Address: _____

City, State, Zip Code: _____