

Athens County Children Services
DENTAL EXAMINATION REPORT

NAME OF CHILD: _____

On _____, the above-mentioned patient was seen in our office for:
(DATE)

(CHECK ONE)

SEMI-ANNUAL EXAM ____ FOLLOW-UP VISIT ____ EMERGENCY ____

TREATMENT

OUR FINDINGS ARE:

NO TREATMENT NEEDED: _____

CLEANING NEEDED: _____

SEALANTS: _____

FILLINGS: _____

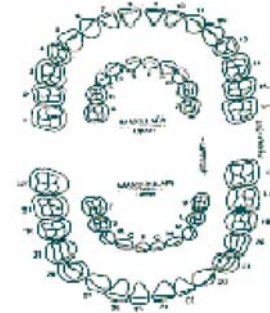
OTHER: _____

MEDICATION PRESCRIBED: _____

IDENTIFY MISSING TEETH WITH AN AX@

FOLLOW UP NEEDED: _____

DOCTOR NAME (PLEASE PRINT)



PLEASE SHOW WHICH TEETH WORKED ON

ADDRESS: _____

SIGNATURE OF DOCTOR

TELEPHONE NUMBER

PLEASE NOTE THAT THIS FORM MUST BE SIGNED BY THE DOCTOR AND GIVEN TO THE CHILD'S CARE TAKER AT THE TIME OF EACH VISIT, OR ATTACH COPY OF STANDARD OFFICE FORM COVERING ABOVE INFORMATION.