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:_____

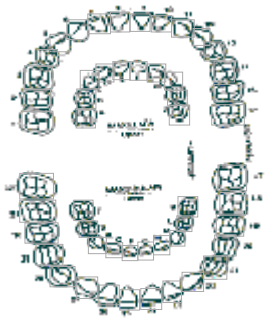
_____

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.