Washington Township Schools

~ A Community of 21st-Century Learners ~

WWW.WTSCHOOLS.ORG

DENTAL EXAMINATION

Student's Name: _____ DOB:_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( )_____

TO BE COMPLETED BY DENTIST

Date of Dental Examination: _____

Please check one:

_____ No treatment is needed at this time and a routine dental prophylaxis and topical fluoride have been completed.

_____ The student is advised to return in _____months for a recheck.

_____ The student is receiving dental treatment at this time. Expected date of completion is_____

Oral findings:

Condition of teeth:		Excellent	Good	Poor
Condition of soft tissue:		Excellent	Good	Poor
Home care:		Excellent	Good	Poor
Attitude:		Excellent	Good	Poor
Restoration:	Yes / No			
	(If yes, their condition)	Good	Fair	Poor
Calculus:	None	Slight	Moderate	Excessive

Dentist Name: _____

Address: _____ City: _____ State: _____ Zip: _____

_____ _____

Signature of Dentist Date