Dental Examination Report

Early Learning
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excellence & equity in education
Puget Sound Educational Service District

Name:______________________________________ Birth Date:________________________________

Please indicate if today's visit is routine exam or follow-up treatment:

Routine exam ☐ Follow-up treatment ☐

Date of Exam: ________________________ Date of treatment: ________________________

Preventative care received today:

- ❑ Cleaning
- ❑ Fluoride Application
- ❑ Sealants

Comments:

Oral Health Status:

- ❑ No oral health disease
- ❑ Active oral health disease
  - ❑ Cavities (#_______)

Comments:

Treatment Received Today:

- ❑ Restoration (#______)
- ❑ Extraction (#______)
- ❑ All restorative treatment completed

Comments:

Treatment Needed at Next Visit:

- ❑ No treatment needed, recall in six months
- ❑ Preventative Care (ex: sealants)
- ❑ Restoration
- ❑ Extraction

Approximate number of visits needed: ___________________

Date of next appointment: ___________________

Referrals:

- ❑ Needs referral to pediatric dentist
- ❑ Needs treatment under general anesthesia
- ❑ Needs referral to other dental specialist

Referred to

____
Name

____
Phone Number

____
Appointment Date

Please list oral health education completed with child's family.

Signature of Provider: ________________________________ Date: ________________________________

Printed Name: ________________________________ Phone: ________________________________

Address: ____