DENTIST REPORT

NAME OF CHILD____

DATE OF BIRTH_____________________________ MALE ____ FEMALE_____

HOME ADDRESS____

STATE____________ ZIP____________

The above named child last visited my office on ______________________.
(date)

At that time all necessary dental corrections had been made. Yes_____ No_____

If the answer is no, fill in the following please:

This child is in need of treatment for one or more of the following:

Primary Teeth _____ Fillings_____ Extraction's_____

Permanent Teeth _____ Fillings_____ Extraction's_____

Diseases of the supporting tissues______________________________

Gross Malocclusion which is producing a facial deformity or is interfering with function _____________________________.

Cleft Palate and/or cleft lip ____________.

Other congenital malformations ____.

Prosthetic replacements for lost or missing teeth _____________________________.

This child is currently under treatment. _____Yes _____No

_____________________ (Date)

_______________________________________D.D.S. (Signature)