Faith Christian SCHOOL

FAMILY DENTIST REPORT

NAME OF CHILD_____

DATE OF BIRTH _____MALE____ FEMALE _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

The above child last visited my off 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 _____extractions

Permanent teeth: _____ fillings _____extractions

Disease of 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 _____

_____ _____D.D.S.
(Date) (Signature)