TRI-CREEK SCHOOL CORPORATION

19290 Cline Avenue **Lowell, Indiana 46356** **(219) 696-6661**

DENTAL EXAMINATION RECORD

(Information on this form may be shared with appropriate personnel for health and educational purposes)

Please PRINT or TYPE

Pupil's Name:______________________________ Birthdate:______________ Sex: Male☐ Female☐

Address:____ Telephone #:______________________________

1. Does your child have any medical problem that may complicate dental treatment? (i.e., allergies, diabetes, respiratory difficulty, history of rheumatic fever, etc.?) Yes☐ No☐

   Explain:____

   ____

THIS PORTION TO BE COMPLETED BY DENTIST

Date exam performed:______________________

Current Dental Status of Patient:

☐ URGENT: abscess formation, nerve exposure, advanced disease state including handicapped individuals.

☐ ROUTINE DENTAL CARE NEEDED: alloys, composites, stainless steel crowns, etc.

☐ PREVENTATIVE DENTISTRY ONLY NEEDED: prophylaxis, fluoride treatment, sealants

☐ NO TREATMENT REQUIRED

☐ OTHER

Pathology Present:

Hard Tissue: Yes☐ No☐ Describe:____

Soft Tissue: Yes☐ No☐ Describe:____

Malocclusion: Yes☐ No☐ Type:____

Orthodontic Referral Recommended**:** Yes☐ No☐

Dentist Signature:____________________________________

Address:____________________________________

____

Phone:____________________________________