Lima City Schools Preschool
925 East Third Street
Lima, Ohio 45804
Fax: 419-996-3301
Phone: 419-996-3692

DENTAL FORM

Child's Name:_____ Sex:_____ Birthdate:_____
Parent/ Guardian Name:_____ Phone:_____
Address:_____

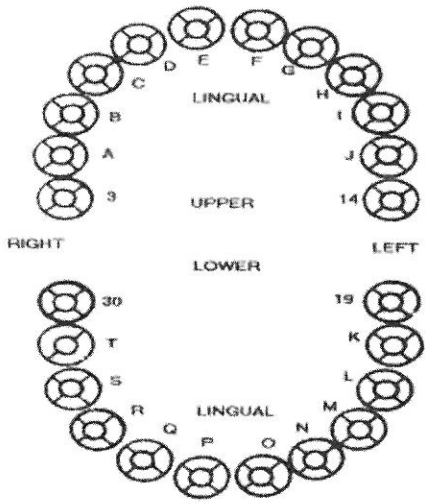
Does the child have any trouble with teeth, gums or mouth that the parent knows about?_____

Date of most recent dental exam_____ Date of next appointment _____

If follow-up is needed, please explain the treatment plan_____

_____

ORAL CONDITIONS BEFORE TREATMENT: *missing ( ), decayed ( ), or filled ( ); indicate restorations*



EXAMINATION AND TREATMENT RECORD

Tooth # or Letter	Surfaces	Date Service Performed	Description of Work

PLEASE CHECK SERVICES PROVIDED:

_____ Fluoride
_____ Prophylaxis
_____ Instruction in oral hygiene
_____ Restoration of decayed teeth
_____ Pulp therapy
_____ Extraction

PRIORITY GROUP:

_____ Needs Attention Immediately
_____ Needs Attention Soon _____ Needs Routine Care

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

Date of Examination _____

Dentist Name _____

Dentist Signature _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Phone _____