Oneida City School District
565 Sayles Street, PO Box 327, Oneida, NY 13421

Dental Exam Form

Child's Name:_____ Date of Birth _____
Address:_____

Dental History:
Is child receiving: Fluoride Supplement: Yes__ No__ Fluoridated Water: Yes__ No__

Child: Has__ Has Not__ previously seen a dentist. Dentist's Name: _____
Date of visit: _____ Reason for Visit: _____

Does child have any trouble with teeth, gums or mouth? Please explain: _____
_____

**************************To Be Filled out by Dentist**************************

The following procedures have been completed:,
_____Dental Exam _____Radiographs _____Prophylaxis _____Fluoride Treatment

My Findings are as follows:

_____ No problems _____ Restorations complete

_____Decay detected (please chart below) _____ Prophylaxis needed

_____Treatment will be completed by me
Appointment scheduled for:_____

_____Referral made
Name of provider referred to:_____
Address_____

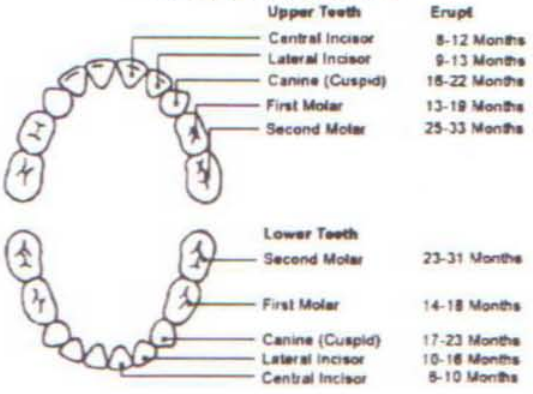
_____Other – please specify_____

Comments:_____

Signature of Dentist_____ Date of Exam_____

Name of Dentist_____ Address _____

Primary Teeth Eruption Chart



Permanent Teeth Eruption Chart