



DENTIST'S REPORT

Child's Name: _____

Age: _____

The following services have been performed:

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Examination | <input type="checkbox"/> Radiographs | <input type="checkbox"/> Prescription for fluoride supplements |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Oral prophylaxis | <input type="checkbox"/> Topical application of fluoride |

The following oral hygiene instruction was provided:

- | | |
|--|--|
| <input type="checkbox"/> Toothbrushing | <input type="checkbox"/> Diet counseling |
| <input type="checkbox"/> Flossing | <input type="checkbox"/> Home/School use of fluoride mouth rinse |

The following statements are applicable:

- | | |
|--|--|
| <input type="checkbox"/> All necessary services have been performed | <input type="checkbox"/> Further treatment is indicated |
| <input type="checkbox"/> No restorative services are required at this time | <input type="checkbox"/> Further appointments have been arranged |

Comments: _____

Please Print or Stamp:

Dentist's Name	Signature
Address	Date Signed
Phone	