



Dentist 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:	

Revised 7/09