



DELPHIAN SCHOOL

# DENTIST EXAMINATION FORM

Student's Name \_\_\_\_\_ Date of Examination \_\_\_\_\_

**Clinical Evaluation:**

Dental Conditions		Comments
Unfilled Teeth Present	Deciduous Permanent	
Removal Apparently Indicated	Deciduous Permanent	
Periodontal Disease		
Malocclusion		
Pathological Oral Soft		
Tissue Lesion Present		
Condition of Oral Hygiene		

1. The student is currently under the following dental care:

2. The student will require the following dental care in the near future:

Signature of Dentist \_\_\_\_\_

Date \_\_\_\_\_ Office Phone \_\_\_\_\_

Office Street Address \_\_\_\_\_

City/State/Zip (Postal Code) \_\_\_\_\_ Country \_\_\_\_\_