Dental School Examination Form

Student Information

Name: ____

Date of Birth: __________________________

Gender: [ ] Male [ ] Female

Student ID: ____

School Name: ____

Grade/Class: ____

Parent/Guardian Information

Name: ____

Contact Number: ____

Email Address: ____

Examination Details

Date of Examination: ____

Examining Dentist: ____

Dental Health Evaluation

Teeth Condition	Healthy	Requires Attention	Notes
Upper Front Teeth	[ ]	[ ]	
Lower Front Teeth	[ ]	[ ]	
Molars	[ ]	[ ]	
Gums	[ ]	[ ]	

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Recommendations

[ ] No further treatment needed

[ ] Additional dental care required (explain): ______________________________

Dentist's Signature

Signature: __________________________ Date: ___________

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