

Dental School Form

Full Name of Student: _____

Date of Birth: _____

Grade/Class: _____

Parent/Guardian Name: _____

Contact Number: _____

Email Address: _____

Reason for Dental Visit:

Routine Checkup

Emergency

Follow-up

Other: _____

Has the student received prior dental care at the school? Yes No

If yes, provide details:

Medical History:

Does the student have any known allergies? Yes No

If yes, specify: _____

Is the student currently on any medication? Yes No

If yes, list: _____

Parent/Guardian Signature: _____

Date: _____

For Dental Office Use Only

Attending Dentist: _____

Treatment Provided: _____

Next Appointment Date: _____