Homes For Kids, Inc.
P.O. Box 683 Niles, OH 44406
phone: 330-544-8005 fax: 330-544-9379

DENTAL EXAM REPORT

Dentist's Name (printed): _____ Exam Date: _____

Patient's Name: _____ DOB: _____

Type of Exam: Initial _____ Annual _____ *Special _____

*Explain: _____

A. Does the child have any known trouble with the teeth, mouth, or gums? Yes ___ No ___

If yes, what is the problem? _____

_____

_____

B. Examination and Treatment (description of work performed during exam) :

_____

_____

_____

_____

C. Dental Needs / Oral Health Summary (check as appropriate) :

_____	Treatment (restoration, extraction, etc.)	_____	Cleaning
_____	Fluoride Treatment of Supplements	_____	Oral Hygiene
_____	Developmental Problem	_____	Dietary Problem
_____	Routine Recall Visits	_____	No Problems
_____	Other: _____		

Dentist's signature: _____ Date: _____

Address: _____

_____