XENIA COMMUNITY SCHOOLS PRESCHOOL

425 Edison Blvd
(937)562-9706 fax (937)374-4218

CHILD DENTAL STATEMENT

Exam Date:_____Child's Name_____ DOB_____

Diagnostic and Preventive Procedures Performed:

- ❑ Clinical Examination
- ❑ X-Rays
- ❑ Prophylaxis
- ❑ Fluoride application
- ❑ **Other** _____

Current Status:

Cavities: _____ **(How Many)** **Recurrent decay around old fillings:** _____ **(How Many)**

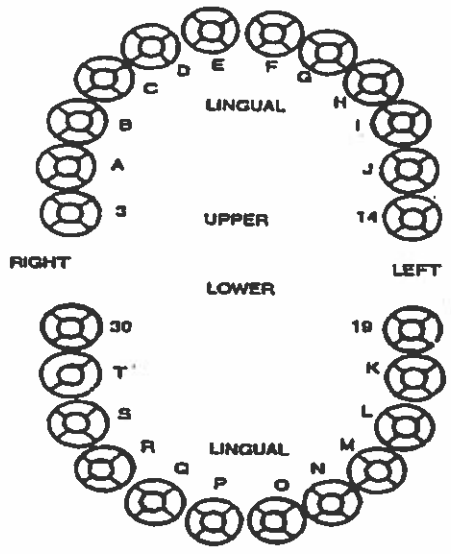
Gums and supporting tissues:

- ❑ Normal & Healthy
- ❑ Slight Inflammation (gingivitis)
- ❑ Moderate Inflammation (gingivitis)
- ❑ Advanced disease (periodontitis)

Other: _____

Recommendation: ***(One selection is required)***

- ❑ No further treatment recommended at this time. Return in _____ months for an examination.
- ❑ Additional dental treatment is required. Treatment plan is identified below.



Tooth # or letter	Description of Dental Services Required

Signature of examining (check one)[] Dentist [] RDH [] Other: Specify_____

Provider Setting:[] Dentist office/clinic [] school [] Other: Specify_____

Address:_____

Phone:_____