RED MOUNTAIN
FAMILY SERVICES, INC.

# Dental Examination Record

Information in this form may be shared with appropriate personnel for health and education purpose.
To be completed by the parent, (this portion only).

______________________________________________________________________________
Last Name | First Name | Date of Birth | Social Security Number

______________________________________________________________________________
Address: Street/City/ZipCode | Telephone

______________________________________________________________ _____Male _____Female
Name of School | Grade Level

______________________________________________________________________________
Parent or Guardian | Address

1. Is Your Child Receiving Fluoride Treatment In School? _____Yes _____No
2. Does Your Child Have Any Medical Problems That May Complicate Treatment? _____Yes _____No
   (i.e. Allergies, Diabetes, Respiratory Difficulty, History of Rheumatic Fever, etc.) Please Explain ______________________________

   ______________________________________________________________________________

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

To Be Completed by Dentist: Current Dental Status of Patient

___**URGENT:**
(Abscess Formation, Nerve Exposure, Advance Disease State Including Handicapped Individuals)

___**ROUTINE DENTAL CARE NEEDED:**
(Alloys, Composites, Stainless Steel Crown, etc.)

___**PREVENTATIVE DENTISTRY ONLY NEEDED:**
(Prophylaxis, Fluoride Treatment, Sealants, etc.)

___**NO TREATMENT REQUIRED:**

___**OTHER:** ____________________________________________

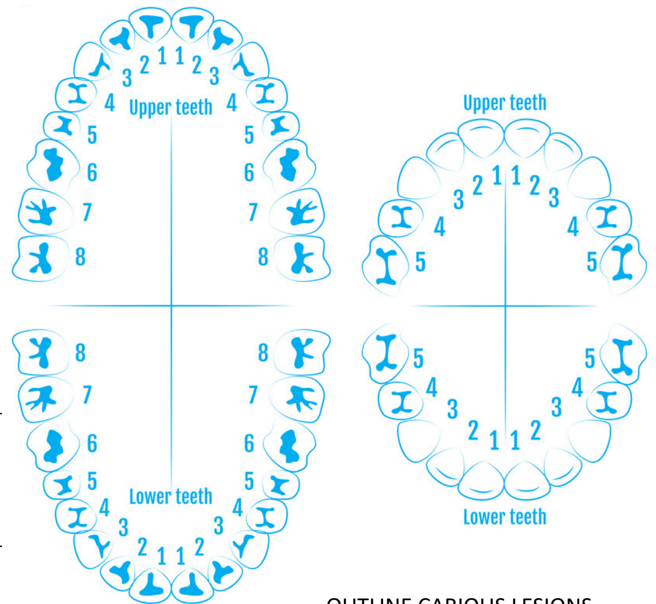
**PATHOLOGY PRESENTS:**

Hard Tissue _____Yes _____No Describe:______________________

Soft Tissue _____Yes _____No Describe:______________________

Malocclusion_____Yes _____No Describe:______________________

**Orthodontic Referral Recommended** _____Yes _____No




OUTLINE CARIOUS LESIONS
SLASH TEETH TO BE REMOVED
X TEETH MISSING
NOTE PATHOLOGY/ LOCATION
BLOCK IN FILLING PRESENT

______________________________________________________________________________
Name of Dental Facility

______________________________________________________________________________
Signature of Dentist | Date

______________________________________________________________________________
Address of Dental Facility

______________________________________________________________________________
Telephone Number | Fax Number

**Official Property of Red Mountain Family Services, Inc.**