



FAMILY DENTIST REPORT

TO THE DENTIST

PATIENT'S NAME	
GRADE	SCHOOL

THE ABOVE NAMED CHILD LAST VISITED MY OFFICE ON / /

AT THAT TIME ALL NECESSARY DENTAL CORRECTIONS HAD BEEN MADE YES NO

IF "NO" TO THE ABOVE QUESTION, PLEASE COMPLETE THE FOLLOWING

PRIMARY TEETH	FILLINGS	<input type="checkbox"/>	EXTRACTIONS	<input type="checkbox"/>
PERMANENT TEETH	FILLINGS	<input type="checkbox"/>	EXTRACTIONS	<input type="checkbox"/>
DISEASES OF THE SUPPORTING TISSUES:		<input type="checkbox"/>		
GROSS MALOCCLUSION WHICH IS PRODUCING A FACIAL DEFORMITY OR IS INTERFERING WITH FUNCTION				<input type="checkbox"/>
CLEFT PALATE AND/OR CLEFT LIP	<input type="checkbox"/>	OTHER CONGENITAL MALFORMATIONS		<input type="checkbox"/>
PROSTHETIC REPLACEMENTS FOR LOST OR MISSING TEETH				<input type="checkbox"/>
THIS CHILD IS CURRENTLY UNDER TREATMENT			YES	<input type="checkbox"/>
			NO	<input type="checkbox"/>

REMARKS

DENTIST'S NAME (PLEASE PRINT)

DENTIST'S SIGNATURE

ADDRESS

DATE

CITY/STATE/ZIP CODE

PHONE