

WHISPERING PINES SEVENTH-DAY ADVENTIST SCHOOL

PROOF OF DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Name: _____ Date of Birth: _____

Address: _____ Telephone: (____) ____ - _____

Street

City

Zip Code

Name of School: _____ Grade Level: _____ Gender: Male Female

Parent or Guardian: _____ Address if different: _____

To be completed by dentist:

Oral Health Status (check all that apply):

YES NO **Dental Sealants Present**

YES NO **Caries Experience/Restoration History**

A filling (temporary or permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

YES NO **Untreated Caries**

At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark brown discoloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If Retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth with temporary fillings are considered sound unless a cavitated lesion is also present.

YES NO **Soft Tissue Pathology**

YES NO **Malocclusion**

Treatment Needs (check all that apply):

- Urgent Treatment** - abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.
- Restorative Care** - amalgams, composites, crowns, etc.
- Preventive Care** - sealants, fluoride treatments, prophylaxis
- Other** - periodontal, orthodontic

Please Note: _____

Signature of Dentist: _____ Date: _____

Address: _____ Telephone: (____) ____ - _____