Margaretta Local School District
Dental Form

Student's Name			Gender ☐ Male ☐ Female
Date of Birth	Age	Date of Dental Examination	Today's Date

The following services have been performed (please check all that apply):

☐ Examination ☐ Prescription for fluoride supplement ☐ Treatment (restoration, pump therapy)	☐ Fluoride application ☐ Orthodontic assessment ☐ Dental sealant	☐ Oral prophylaxis (cleaning) ☐ Radiographs ☐ Other: _____

The following oral hygiene instruction was provided (please check all that apply):

☐ Tooth ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouth rinse
☐ Other: _____

The following statements are applicable (please check all that apply):

☐ All necessary preventative services have been performed (fluoride treatment, prophylaxis)

☐ No restorative services are required at this time

☐ Further treatment is indicated (see comments below)

☐ Further appointments have been arranged (orthodontic, restorative)

☐ Routine recall visits recommended

Comments:
_____
_____
_____
_____
_____
_____

Dentist's Signature	Print Name	Phone
Address		Date Signed
City	State	Zip Code