(To be completed by the dentist)

SCHOOL _____

NAME _____

ADDRESS _____

PHONE # _____ BIRTHDATE _____

PARENT NAME _____

Child was examined on _____
(Date)

The following services have been performed: (*Please Check*)

Radiographs _____

Oral Prophylaxis _____

Fluoride Treatment _____

Restorations _____

The following statements are applicable: (*Please Check)*

All necessary services have been performed _____

No restorative services are required at this time _____

The child is in treatment and future appointments have been arranged _____

_____,D.D.S.
Signature