Grace Christian School Dental Record
Faith . Preparation . Leadership . Service . Community . Spirit

(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