



Dental History

Student Information

Student's Name _____
Last *First* *Middle*

Date of Birth _____ Gender Male Female Grade _____

Home Address _____

Home Telephone _____

Dentist's Name _____ Dentist's Phone _____

Dental Information

This section is to be completed by the child's dentist.

Date of Visit: _____

At the time of the visit had all necessary dental corrections been made? Yes No

If no, please complete the following on treatment:

_____ Primary Teeth _____ Fillings _____ Extractions

_____ Permanent Teeth _____ Fillings _____ Extractions

_____ Disease of supporting tissues (*please describe*) _____

_____ Gross Malocclusion, which is producing a facial deformity or is interfering with function (*please describe*) _____

_____ Cleft palate and/or cleft lip (*please describe*) _____

_____ Other congenital malformations (*please describe*) _____

_____ Prosthetic replacement for lost or missing teeth (*please describe*) _____

Is the child currently under treatment? Yes No

If yes, please explain _____

Has the child received topical F applications? Yes No

Please use the space provided to list any other dental conditions or concerns.

Dentist's Signature _____ Date _____

Dentist's Address _____