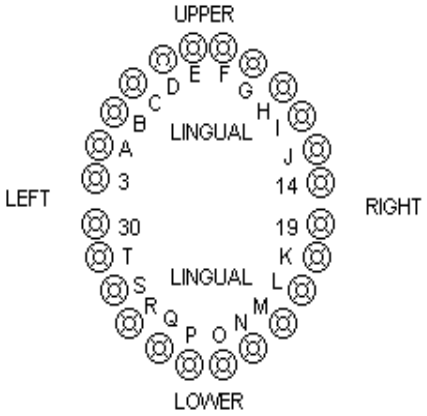
Glen Cove Child Day Care Center, Inc

PO BOX 191 Glen Cove, NY 11542 516 671-2880 Fax 516-671-7401

Dental Exam Form

Child's Name: _____ D.O.B.: _____

Parent Name: _____ Date of Visit: _____



Key: Missing Decayed Filled

EXAM:

_____Professional dental exam completed
_____X-rays Taken
_____Preventative Care provided cleaning, fluoride, Oral health instruction

FINDINGS:

_____All findings are within normal limits.

RESTORATIVE CARE PROVIDED:

_____ Fillings
_____ Crowns
_____ Extractions
_____ Other _____

FOLLOW UP:

_____ Further Treatment needed_____
_____

_____ Referred to: _____
_____Additional Information_____

_____

_____

*********Please complete the information below*********

_____ Treatment is currently complete.
_____ Treatment is not complete. _____ Follow up appointment date _____

_____Next exam /cleaning due_____ months
_____Vitamins with Fluoride have been prescribed

The above service(s) were completed as indicated:

Signature of Dentist: _____ Date: _____

Printed name and phone/stamp: _____

Please return this form to the health office or

Request it to be faxed to: