St. Louis Public Schools

Early Childhood/Early Childhood Special Education

801 N. 11th Street, St. Louis, MO 63101

Dental Examination Report

DATE OF EXAM: _____

CHILD'S NAME: _____ **SEX:** _____ **BIRTH DATE:** ____/____/____ **AGE:**_____

PARENT(S) NAME: _____ **PHONE NUMBER:** _____

INSURANCE NUMBER (MEDICAID OR PRIVATE INSURANCE): _____

Diagnostic and Preventive Procedures Performed:

- ❑ Clinical Examination
- ❑ X-Rays
- ❑ Prophylaxis
- ❑ Fluoride application
- ❑ **Other** _____

Current Status:

Cavities: _____ **(How Many)** **Recurrent decay around old fillings:** _____ **(How Many)**

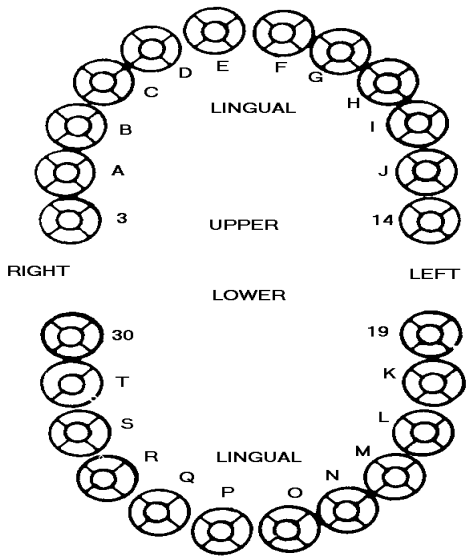
Gums and supporting tissues:

- ❑ Normal & Healthy
- ❑ Slight Inflammation (gingivitis)
- ❑ Moderate Inflammation (gingivitis)
- ❑ Advanced disease (periodontitis)

Other: _____

Recommendation: *(One selection is required)*

- ❑ No further treatment recommended at this time. Return in _____ months for an examination.
- ❑ Additional dental treatment is required. Treatment plan is identified below.



Tooth # or letter	Description of Dental Services Required

_____ _____ _____

Dentist Name (Please Print) Signature Date

Revised 02/2017

Address, City, State & Zip Code

Phone No.