

CHAMBERSBURG AREA SCHOOL DISTRICT

Family Dentist Report

Grade _____

Name _____ Sex _____ Birthdate _____

Last

First

MI

Address _____

The above named child last visited my office on _____ (DATE).

Currently, all necessary dental corrections had been made. Yes _____ No _____

If the answer is **NO**, fill in the following:

This child is in need of treatment for one or more of the following:

Primary teeth _____ Fillings _____ Extractions _____

Permanent teeth _____ Fillings _____ Extractions _____

Diseases of the supporting tissues _____

Gross malocclusion, which is producing facial deformity or is interfering with function _____

Cleft palate and/or cleft lip _____ Other congenital malformations _____

Prosthetic replacements for lost or missing teeth _____

This child is currently under treatment. Yes _____ No _____

Date submitted _____

Dentist's signature _____

Office address _____