CHAMBERSBURG AREA SCHOOL DISTRICT

Family Dentist Report

Grade_____

Name_____
Last First MI

Sex_____ Birthdate_____

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_____

Date Submitted _____

Dentist's Signature_____**DDS/DMD**

Office Address_____

11/08