Year: ____________________

PO Box 1117 1602 W. Ferguson Rd
Mt. Pleasant TX 75455
(903)575-2092 fax (903)575-2077

Dental Exam

☐ EHS ☐ Head Start ☐ Pre-K

Child's name/ *Nombre del Niño*	Birthday/ *Fecha de Nacimiento*	Room/*Salon*

TYPE OF EXAM ☐ ROUTINE VISIT ☐ FOLLOW UP TREATMENT

Section 1-Preventive Care Received Today

- ☐ Cleaning
- ☐ Fluoride
- ☐ Exam
- ☐ Sealants
- ☐ X-Rays

Comments:___________________________________
____
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____

Section 2- Treatment Received Today

- ☐ Restorations
- ☐ Pulp Therapy
- ☐ Extraction
- ☐ None

Comments:___________________________________
____
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____
____

Section 3- Further Treatment Needed

☐ None (6 month recall visit)

6 month recall visit Appt. Date_____________

☐ Restorations

☐ Pulp Therapy

☐ Extraction

Next Appt Date for Treatment: ______________

approximate number of visits needed: ____

☐ Hospital Case Date: ___________

☐ Other

☐ No Further Treatment Needed

Dentist Name (*Please Print*):_________________________________
Address: ___________________City___________________________, TX Zip Code__________________
Phone Number: ______________________________________
Dentist Signature: ___________________________________ Date: _____________________________