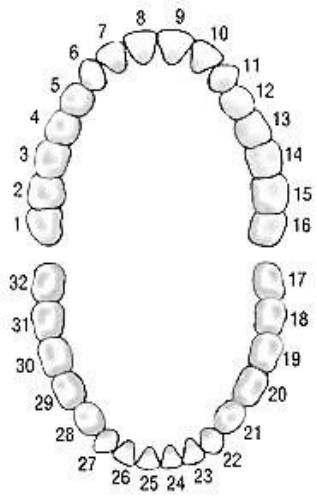
The Learning Nest Preschool Dental Exam Form

2878 Maysville Pike, Zanesville, Ohio 43701
FAX NUMBER: 740-454-0723 ATTN: The Learning Nest Preschool

Child's Name (Please Print)	**Date of Birth**
Parent's Name	**Preschool:** **The Learning Nest Preschool**

Is the child now receiving any of the following?

(If yes, include length of time receiving fluoride)
Topical fluoride application: ___ No ___ Unknown ___ Yes _____
Fluoridated water: ___ No ___ Unknown ___ Yes _____
Fluoride supplement diet: ___ No ___ Unknown ___ Yes _____
_____ Tablets _____ Liquid
Does the child have any trouble with teeth, gums or mouth? ___Yes ___No
If so, what kind? _____
Has the child previously seen a dentist? ____Yes ____ No
Dentist Name _____ Date of last visit _____
Is child under physician's care? ____ Yes ____ No
Physician Name _____
Is child receiving medication? ____ Yes ____ No



Services provided this visit:

Tooth Number	Description of work
_____	_____
_____	_____
_____	_____

Is follow-up required? ___Yes ___ No (If yes, see section below)

Name Of Dentist	**Telephone Number ( )**
Street Address	
Dentist Signature	**Date Signed**

****PLEASE COMPLETE THIS SECTION FOR FOLLOW-UP REQUIREMENTS:****

Please provide a written summary of the following services required:

* For the relief of pain or infection
* Restoration and/or pulp therapy of decayed permanent teeth
* Extraction prophylaxis & instructions in self-care oral hygiene procedures

Recommended follow-up dental needs (check all that apply):

( ) A. Treatment (restoration, pulp therapy, extraction)
( ) B. Cleaning
( ) C. Fluoride
( ) D. Other (please specify below)

_____

Approximate number of visits need to be complete care _____

Has a follow-up appointment been scheduled? _____ Yes _____ No Date: _____