Children's Learning Centers of Fairfield County
Proof of Dental Exam form


**To be completed by the Parent** (Please Print)

| Child's Name: Last First Middle | Birthdate: Month/ Day/Year |
|---|---|
| Address: Street City Zip Code | Home Telephone Number: |
| Center Name: | Class: |
| Parent or Guardian's Name | Child's Gender:<br>Male Female |

**To be Completed by the Dentist**:

**Oral Health Status** (check all that apply)

( ) Yes ( ) No Dental Sealants Present

( ) Yes ( ) No Caries Experience/ Restoration History—a filling or a tooth missing because it was extracted for carries or missing permanent 1st molars

( ) Yes ( ) No Untreated Caries

( ) Yes ( ) No Soft Tissue Pathology

( ) Yes ( ) No Other, please specify: _____

( ) Yes ( ) No Child received cleaning and prophylactic fluoride treatment in the past 6 months

**Treatment Needs** (check all that apply)

( ) Urgent Treatment: abscess, nerve exposure, advanced disease or pain, infection or swelling

( ) Restorative care: amalgams, composites, crowns

( ) Preventative Care: Sealants, fluoride treatment, prophylaxis

( ) Other, please specify: _____

**Date of Next Appointment**: _____

**Signature of Dentist:**_____ **Date of exam:**_____

**Address:** _____ **Telephone number:**_____