

TRENTON PUBLIC SCHOOLS
Trenton, New Jersey
Office of School Health Services

EC-5

DENTAL EXAMINATION/TREATMENT FORM

Section A: To be completed by parent/guardian

PUPIL'S NAME _____ BIRTHDATE _____

ADDRESS _____

SCHOOL/GRADE _____

Section B: To be completed by child's dentist

REPORT OF EXAMINATION

Please circle tooth (teeth) being treated

Tooth Chart																	
RIGHT									LEFT								
UPPER	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	UPPER
				A	B	C	D	E	F	G	H	I	J				
LOWER	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	LOWER
				T	S	R	Q	P	O	N	M	L	K				

Comments: Please check all that apply

_____ fluoride treatment

_____ cavities treated

_____ sealants

_____ further treatment necessary

_____ cleaning

_____ treatment completed

_____ x-rays

_____ **date of next appointment**

 Printed Name of Dental/Examiner

 Signature of Dental/Examiner

 Date

 Phone Number

Please return this form to your child's school once it is completed by the dentist.