EAST TROY
COMMUNITY SCHOOL DISTRICT

DENTAL EXAMINATION REPORT

☐ Leona Doubek Elementary	☐ Prairie View Elementary	☐ East Troy Middle School	☐ East Troy High School
Phone: 262-642-6730	Phone: 262-642-6720	Phone: 262-642-6740	Phone: 262-642-6760
Fax: 262-642-6723	Fax: 262-642-6788	Fax: 262-642-6743	Fax: 262-642-6776

Teeth are important to your child's health, comfort, behavior, progress in school and personal appearance. To safeguard these things, we advise you to take your child to your family dentist for an examination and whatever dental care may be necessary.

Last Name:_____ First Name:_____ Date of Birth:_____ ☐M ☐F

Parent's Name:_____ Home #:_____ Cell #:_____

Dentist's Name:_____ Phone #:_____ Fax #:_____

Dentist's Address:_____ City:_____ St:_____ Zip:_____

TO BE COMPLETED BY THE DENTIST

Oral health status (check all that apply):

☐ Dental Sealants Present

☐ Caries Experience/Restoration History - A filling (temporary/permanent) OR a tooth this is missing because it was extracted as a result of caries OR missing permanent 1st molars

☐ Untreated Caries - At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Soft Tissue Pathology

☐ Malocclusion

Treatment needs:

☐ Urgent Treatment - abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection or swelling

☐ Restorative Care - amalgams, composites, crowns, etc

☐ Preventive Care - sealants, flouride treatment, prophylaxis

☐ Other - periodontal, orthodontic: _____

I have examined the teeth of the student named above and have completed all dental work that I found necessary at this time.

Dentist's Signature:_____ Date:_____