SOUTH CENTRAL COMMUNITY SCHOOL CORPORATION

Dental Examination History Form

The following should be filled out by the student's dentist:
(Please Print)

Name: _____ School: _____

Address: _____

Code:
No Defect - 0
Defect - Note Condition

Teeth

Malocclusion: _____

Cavities: _____

Present Status

Restorations Completed: _____

Appointments Scheduled: _____

Orthodontic Care: _____

Recommendations: _____

_____

Dentist's Name: _____
(Please Print)

Dentist's Signature: _____