

# County of Centre



## CHILDREN AND YOUTH SERVICES

### BOARD OF COMMISSIONERS

JON W. EICH, *Chair*  
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**DIRECTOR**  
CAROL M. SMITH

## REPORT OF DENTAL EXAMINATION

NAME OF CHILD: \_\_\_\_\_

DATE OF DENTAL EXAM: \_\_\_\_\_

1. The results of examination of the hard and soft tissue of the oral cavity:

2. X-rays needed for diagnostic purposes: \_\_\_\_\_ Yes \_\_\_\_\_ No

3. No further treatment is necessary at this time: \_\_\_\_\_

4. Treatment is required at this time: \_\_\_\_\_  
Please list necessary treatment below:

\_\_\_\_\_  
Examining dentist's signature

\_\_\_\_\_  
Date

Next scheduled visit: \_\_\_\_\_