ST JUDE
REGIONAL CATHOLIC SCHOOL

4820 Walbridge Street Rockville, MD 20853

DENTAL HEALTH RECORD

PART ONE: To be completed by parents / guardians.

Please fill in all blanks completely. Please PRINT except where a signature is required.

Name of Student_____

Date of Birth _____ Grade (A or B)_____

DENTIST INFORMATION:

Name_____

Address_____

_____

Telephone number_____

ORTHODONTIST INFORMATION (If Applicable):

Name_____

Address_____

_____

Telephone number_____

PLEASE CHECK WHERE APPROPRIATE:

My Child:
_____ Has never been examined by a Dentist
_____ Visits a Dentist for regular examinations
_____ Wears braces
_____ Wears a retainer
_____ Has dental fillings
_____ Comments / Concerns I have concerning my child's Dental health

_____

_____

_____ _____

Signature of Parent / Guardian Date

TURN OVER FOR PART TWO TO BE COMPLETED BY DENTIST

<u>PART TWO:</u> To be completed by a Dentist.

Date of Last Dental Examination _____

Please check where appropriate regarding student's current Dental Health:

_____The student named on this record is my patient

_____ Receives regular examinations

_____ No treatment is necessary at this time

_____ Currently undergoing treatment

_____ Needs to schedule for treatment

_____ Refuses treatment for current problem

Concerns / Special Instructions regarding this student:

_____

_____

_____

_____

_____

_____D.D.S. _____

Signature of Dentist Date