

MONONGALIA COUNTY SCHOOLS DENTAL FORM

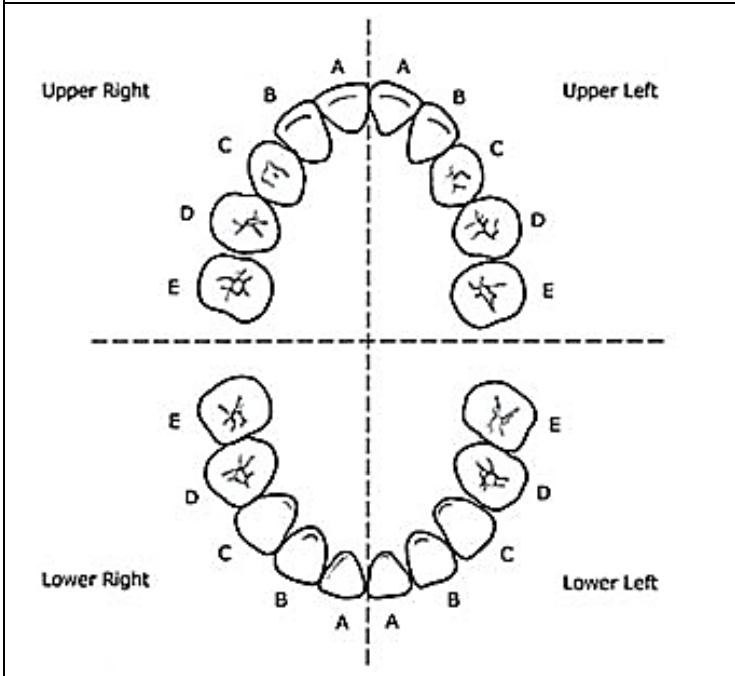
Child's Name:	Date of Birth:	Gender:
Address:		Phone:

Dental Needs: <input type="checkbox"/> Cleaning <input type="checkbox"/> Exam <input type="checkbox"/> Fluoride Treatment Received <input type="checkbox"/> Sealant Administration <input type="checkbox"/> No Problems Noted	Treatment Required: <input type="checkbox"/> Restoration <input type="checkbox"/> Pulp Therapy <input type="checkbox"/> Extraction <input type="checkbox"/> Other _____
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Oral conditions prior to today's visit: (Please indicated on diagram all that applies)

Missing Tooth: (X) Decayed Tooth: (=) Filled Tooth: (●)

DATE	TOOTH #	UR/UL LR/LL	SURFACE	DESCRIPTION OF WORK
				NEXT SCHEDULED APPOINTMENT



Provider Signature required for validation:

Date of Service: _____

Name of Clinic: _____

Signature of Dental Provider

Please return this form to:

Monongalia County Schools
 Head Start Office
 1433 Dorsey Avenue
 Morgantown, WV 26501
 Fax: (304) 291-9324