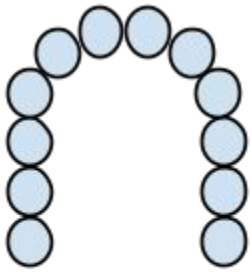
MARION CITY SCHOOLS PRESCHOOL
420 PRESIDENTIAL DRIVE
MARION, OH 43302

Dental Form

Child's Name_____ sex_____ D.O.B_____

Parent/Guardian's Name_____ Phone_____

Address_____ Zip Code_____ Center_____

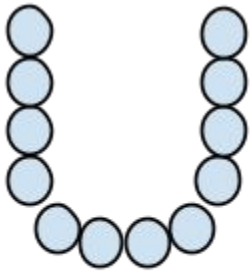


Solid area indicates filing present

Zebra stripes indicate decay present

Vertical line indicates to be extracted

Indicates missing tooth



If follow-up is needed, please explain the treatment plan.

Is there any indication of baby bottle tooth decay?
____ Yes ____ No

1) How many restorations are needed?_____

2)How many visits will be needed to complete the follow-up?_____

3)Date of next appointment?_____

PLEASE CHECK SERVICES PROVIDED:
__ Flouride __Prophylaxis __ Instruction in oral hygiene
__ Restoration of decayed teeth __ Pulp therapy __ extraction

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SERVICES PROVIDED: (Please record each treatment on a separate line)

Month	Day	Year	Tooth	Surface	Material	Description of Work

Treatment Code: Surfaces, M=Mesial, D=Distal, O=Occiusal, L=Lingual, I=Incisal, B=Buccal or Libial, A=Amalgam, S=Sillicate, P=Arcylic, C=Steel Crown, 0=Other

Important: ___ Check if additional work required___ Check if all work for this child has been completed
___ Check if treatment discontinued: Explain above

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

Date of examination_____

Dentist Signature _____ Address_____

City_____ Zip Code_____