#3: CHILD DENTAL HEALTH/DENTAL EXAM FORM

Child's Name _____ Date of Birth _____

SECTION 1: Completed by parent/guardian

1. Has your child been to the dentist? D No D Yes- if 'Yes', date of child's last dental visit _____
2. Does your child have (or had) cavities or caries? D No D Yes- If 'Yes', how many? _____ 3.
   Does your child have any problems with his/her teeth, gums, or mouth? D No D Yes
   If 'Yes', please describe _____
4. How many times a day does your child brush his/her teeth?

SECTION 2: Completed by child's Dentist

1. Date of child's most recent:
   Dental Examination ___ Teeth Cleaning Fluoride Treatment
2. Has child ever needed dental treatment? 0 No O Yes
   If **Yes,** type of dental treatment _____
   Has dental treatment been completed? D No D Yes - if 'Yes', date of completion _____
3. Date of child's next dental visit _____

Dental Office Stamp

My signature certifies the accuracy of this information.

Dentist's Signature _____

Date _____