



# SCHOOL ENTRY DENTAL EXAMINATION

Health and Wellness Services

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Nombre del Estudiante \_\_\_\_\_ Fecha de Nacimiento \_\_\_\_/\_\_\_\_/\_\_\_\_

Dirección \_\_\_\_\_

Ciudad/Código Postal \_\_\_\_\_

Escuela \_\_\_\_\_

Nombre del Dentista \_\_\_\_\_ Teléfono del Dentista \_\_\_\_\_

## LOSIGUIENTE A COMPLETAR POR EL DENTISTA QUE REALIZA EL EXAME

### THE FOLLOWING TO BE COMPLETED BY EXAMINING DENTIST

- 1. Untreated decay in permanent teeth  YES  NO
- 2. Untreated decay in permanent teeth-----  YES  NO

*If yes, to 1 or 2, please answer a, b, and c below.*

- a. Decay is classified as early childhood caries/baby bottle caries (affecting the primary maxillary anterior teeth, followed by involvement of the primary molars; mandibular incisors may not be affected).....  YES  NO
- b. Decay is classified as rampant caries in permanent teeth .....  YES  NO
- c. Child is experiencing pain *and/or* infection .....  YES  NO

- 3. Occlusion is within normal range for age.....  YES  NO
- If no, immediate follow-up is indicated.....  YES  NO

4. Oral hygiene.....  Optimal  Needs Improvement

5. This is child's first dental treatment completed.....  YES  NO

6. All necessary dental treatment completed .....  YES  NO

If no, appointments are made for completing treatment .....  YES  NO

COMMENTS:

Dentist's signature \_\_\_\_\_ Date \_\_\_\_\_