

# Adriel Dental Record

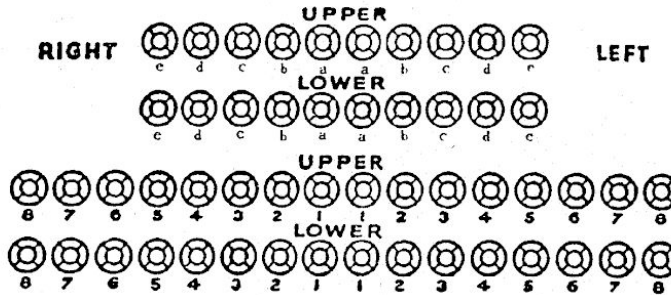
Adriel School, Inc.  
 22897 US 20-A  
 Archbold, Ohio 43502  
 419-445-1980  
 Fax: 1-888-820-8966

Name of Youth: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Adriel Office Use	
Teaching Parent/Foster Parent Copy	_____
File Copy	_____
Caseworker Copy	_____

## ADRIEL SCHOOL DENTAL RECORD

NAME OF CHILD \_\_\_\_\_ NAME OF HOME OR INSTITUTION \_\_\_\_\_ AGE \_\_\_\_\_



### LEGEND

- Fillings Present—Fill in, with **black**, the surfaces involved.
- Cavities—Outline, in **red**, the surfaces involved. (✓) when filled.
- Missing Teeth—Indicate with large **black M**.
- Teeth Indicated for Extraction—Indicate with large **red X**.
- Teeth Extracted—Indicate with large **black X**.
- Gum Inflammation—Indicate, in **red**, beneath teeth involved.

<b>EXAMINATION</b> Deciduous teeth—Decayed? Stained? Calculous? Describe:	Permanent teeth—Decayed? Stained? Calculous? Describe:
Gums—Inflammation Describe:	Mucous membranes Describe:

Other oral manifestations  
 Describe:

Do irremediable defects of the teeth exist?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Is adequate fluoride present in water supply?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is malocclusion present	<input type="checkbox"/>	<input type="checkbox"/>	Have fluoride applications been provided?	<input type="checkbox"/>	<input type="checkbox"/>

- RECOMMENDATIONS:
- X-rays
  - Restorations
  - Dental prophylaxis
  - Extractions
  - Fluoride applications
  - Orthodontic service
  - Other

Continuous record of all services rendered on other side.

(Sign) \_\_\_\_\_ Dentist making examination

Date \_\_\_\_\_

