

Adriel Dental Record

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Fax

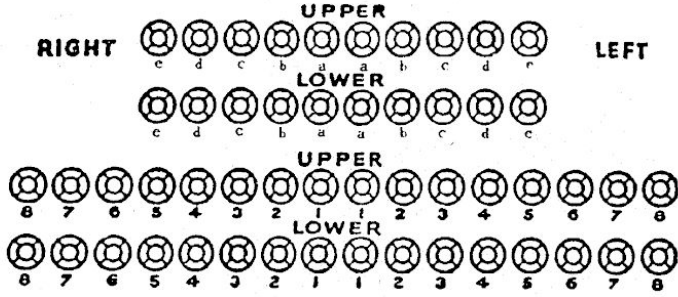
Name of Youth: _____

Date of Exam: _____

ADRIEL SCHOOL DENTAL RECORD

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

NAME OF CHILD _____ NAME OF HOME OR INSTITUTION _____ AGE _____



LEGEND

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

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

Other oral manifestations
Describe:

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

