

# Adriel Dental Record

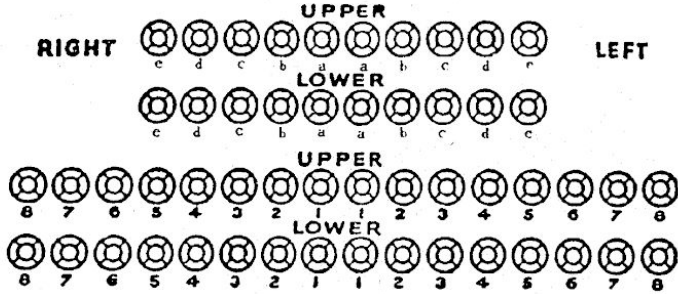
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Phone (419) 724-0276  
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Name of Youth: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

## ADRIEL SCHOOL DENTAL RECORD

<b>Adriel Office Use</b>	
Teaching Parent/Foster Parent Copy	_____
File Copy	_____
Caseworker Copy	_____

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



**LEGEND**

- |   |   |
|---|---|
| Fillings Present—Fill in, with <b>black</b> , the surfaces involved.<br>Cavities—Outline, in <b>red</b> , the surfaces involved. (✓) when filled.<br>Missing Teeth—Indicate with large <b>black M</b> . | Teeth Indicated for Extraction—Indicate with large <b>red X</b> .<br>Teeth Extracted—Indicate with large <b>black X</b> .<br>Gum Inflammation—Indicate, in <b>red</b> , 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	No	Is adequate fluoride present in water supply?	Yes	No
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 \_\_\_\_\_

**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? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No Is malocclusion present? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Is adequate fluoride present I water supply? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No Have fluoride applications been provided? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<b>RECOMMENDATIONS:</b> X-rays Restorations Dental prophylaxis Extractions Fluoride applications Orthodontic service Other	

Continuous record of all services rendered on other side.

\_\_\_\_\_  
 Name of Dentist Performing Exam

\_\_\_\_\_  
 Signature of Dentist Performing Exam

\_\_\_\_\_  
 Date

Stamp/Name of practice, address, and telephone number: