School City of Mishawaka
Health Services Department
Dental Examination Form

Name _____ **Age** _____
Last **First** **Middle**

Number of Cavities: Permanent _____

Primary (excluding centrals & laterals) _____

Occlusion: **Normal** _____ **Abnormal** _____

Treatment Recommended _____

_____

_____

_____

Oral hygiene: _____

Comments: _____

_____

Did the patient arrange for necessary treatment? Yes _____ **No** _____

Habits: Thumb, finger, tongue, nail biting, mouth breathing, etc.:

_____

Remarks: _____

_____

_____

_____

_____

_____ _____
Dentist's Printed or Typed Name Dentist's Signature

_____
Date

612-00 Revised 3/95