PRESCHOOL DENTAL EXAMINATION

Name:_____

Parent/Guardian:_____

D.O.B.:_____ Date of Exam:_____

Oral Hygiene:_____

(T) Teeth:

_____
_____
_____
_____

(P) Teeth:

_____
_____
_____
_____

Treatment:

_____
_____
_____
_____

Recommendations:

_____
_____
_____
_____

Doctor's Signature: _____

HN 02/18
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