PERKINS SCHOOL HEALTH HISTORY
DENTIST'S REPORT

The following services have been performed:

Name _____

_____ Examination

Date of Birth _____

_____ Diagnosis

Date of Exam _____

_____ Radiographs

_____ Oral prophylaxis

_____ Prescription for fluoride supplements

_____ Topical applicaiton of fluoride

The following oral hygiene instruction was provided:

_____ Toothbrushing

_____ Flossing

_____ Diet counseling reflecting relation of diet to dental health

_____ Home/school use of fluoride mouthrinse

The following statements are applicable:

_____ All necessary services have been performed

_____ No restorative services are required at this time

_____ Further treatment is indicated

_____ Further appointments have been arranged

COMMENTS: _____

_____

_____

PLEASE PRINT OR STAMP

Dentist's name_____ Dentist's signature_____

Address _____

Phone _____ Date signed _____

Revised 4/04