The Salvation Army Children's Services
425 Allentown Drive, Suite 1
Allentown, PA 18109
(610) 821-7706

Dental Examination Form

Patient's Name: ____

Dentist's Name: ____

Dentist's Address: ____

Date of Examination: ____

_____ Initial Examination OR _____ Follow-up Examination

Dental History:

_____ Routine Check-ups _____ Specialists

_____ Has Never Seen Dentist _____ Dental Emergencies Only

X-rays for diagnostic purposes deemed necessary ____________________________

Restored Teeth (#1-32 or A-T) ____

Missing Teeth (#1-32 or A-T) ____

Are missing teeth adequately replaced or space maintainers inserted?
_____ YES _____ NO

Has the child ever had problems with previous dental treatment?
_____ YES _____ NO

Has the child had adequate dental treatment in the past?
_____ YES _____ NO

Hygiene:
_____ Excellent _____ Good _____ Poor

PLEASE FILL OUT BOTH SIDES AND SIGN AT THE BOTTOM OF THE BACK PAGE

	Within Normal Limits	Pathology
Lips	____________	____________
Labial & Buccal Vestibules	____________	____________
Gingiva	____________	____________
Floor of Mouth	____________	____________
Tongue	____________	____________
Oral Pharynx	____________	____________
Alveolus	____________	____________
Salivary Glands	____________	____________
Occlusion	____________	____________

	Not Present	Present (explain)
Facial Abnormalities	____________	____________
Lymphadenopathy	____________	____________

Carious Teeth (#1-32 or A-T) ______________________________

Extractions Necessary (#1-32 or A-T) ______________________________

Periapical Pathology (#1-32 or A-T) ______________________________

All Necessary Work Completed ______________________________ (Date)

Six (6) Month Check-up Due ______________________________ (Date)

Dentist's Name (please print) ______________________________

Dentist's Signature ______________________________

Date ______________________________