



Eastport/South Manor Central School District
149 Dayton Avenue
Manorville, New York 11949
(631) 874-6720 Fax (631) 878-6308

STANDARD DENTAL FORM

Student's Name _____ Date of Birth _____ Sex _____

School _____ Grade _____

REPORT OF DENTAL EXAMINATION

This is to certify that I have examined the teeth of the above-named student and I find:

- Oral hygiene is: _____ Good _____ Fair _____ Poor
• Number of teeth filled _____
• Number of teeth extracted _____
• All necessary dental work has been completed _____
• Treatment is in progress _____
• No dental work is necessary _____
• Is child under regular dental supervision? _____

REMARKS

Please elaborate on any of the above or make any recommendations that would assist the school in helping this child. _____

DATE OF EXAM _____

Dentist's Signature _____

Office Address _____

Date _____ Phone Number _____

Fax Number _____

PLEASE RETURN THIS COPY TO SCHOOL