CARLSTADT PUBLIC SCHOOL

CARLSTADT, NEW JERSEY 07072

DENTAL HEALTH EXAMINATION

CHILD'S NAME_________________________Date of Birth _____________ Age_________

ADDRESS____

This dental examination form is to be completed by your dentist.

General Dental Condition ____

Recommended Dental Care____

Signature of Examining Dentist____

Dentist's Name (please print/type)____

Dentist's Address (please print/type)____