HILLSBORO PRESCHOOL
CHILD DENTAL EXAM FORM

Child's Name:_____

Child's Date of Birth:_____

Preschool Teacher:_____

Date of Dental Exam:_____

Please check the appropriate space pertaining to this child:

( ) Needs treatment (restoration, pulp therapy, extraction)
( ) No treatment need at this time
( ) Treatment is complete

Is this child up-to-date on scheduled age-appropriate preventative care?
( ) Yes ( ) No

Provider Name: (please print)

_____

Provider Address:_____

Provider Business Phone:_____

Signature and Credentials of Provider:

_____

Date:_____

Please return this form to: **Hillsboro Preschool**
500 US 62 South, Hillsboro, OH 45133
Fax: (937) 393-2418