Heritage Christian Preschool

DENTAL STATEMENT

Child's Last Name:	First Name:	DOB	Age
Address:	Zip	Phone:	
Parent/Guardian		Heritage Christian Preschool	

Parental Consent for Release of Medical Statement

X _____ _____

Parent Signature Date Signed

DENTAL HISTORY

1. Does your child receive any of the following:
   Topical fluoride ☐ Fluoridated water ☐ Fluoride supplement diet ☐
2. Does your child have any trouble with teeth, gums, or mouth? **Yes** ☐ **No** ☐
   Explain_____
3. Has your child seen a dentist before? **Yes / Date of last visit**_____ **No** ☐
4. Is your child under a physician's care? **Yes/ Name & Date**_____ **No** ☐
5. Is your child on any medication? **Yes** ☐ **No** ☐ **If yes, please list:**_____

DENTAL EXAMINATION AND TREATMENT RECORD

	Yes	No	Follow-up
Exam			
Cleaning			
Fluoride			
Dental Prophylaxis			
Restoration			
Pulp Therapy			
Extraction			
Relief of Pain or Infection			

List any Dental Needs/Concerns

Dietary:_____

Oral Habits/Hygiene:_____

Developmental:_____

Other:_____

This statement affirms that the above child is in suitable condition for enrollment in the Preschool Program.

Dentist Signature_____ **Date**_____

Dentist Address:_____

City_____**State**_____ **Zip**_____

Phone_____**Fax**_____