KEEPING KIDS SAFE, INC.
Foster Care Agency

Dental Examination

Child's Name: _____ Today's Date: _____

DIAGNOSTIC & PREVENTATIVE PROCEDURES PERFORMED:

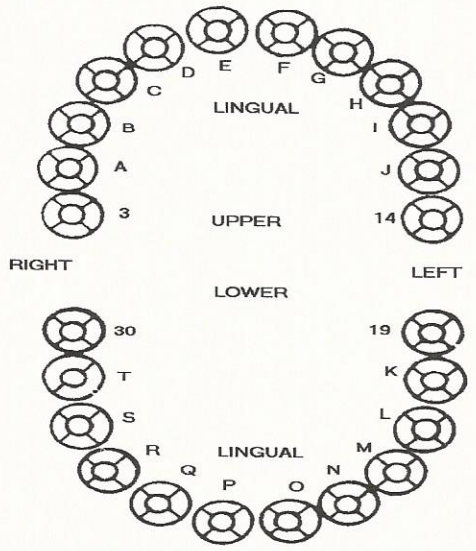
☐ Clinical Exam ☐Prophylaxis ☐ X-rays ☐ Fluoride Application
☐Other _____

GUMS & SUPPORTING TISSUE:

☐ Normal & Healthy ☐ Slight Inflammation (gingivitis)
☐ Moderate Inflammation (gingivitis) ☐ Advanced Disease (periodontitis)
☐ Other: _____

RECOMMENDATIONS:

☐ No further treatment recommended at this time. Return in _____ months for exam.
☐ Additional dental treatment work is required. Dental treatment is identified below.



Tooth # or Letter	Description of Dental Services Required

Doctors Name: _____

Address: _____

Phone Number: _____

_____ _____
Signature of Dentist Date