KEEPING KIDS SAFE, INC. Foster Care Agency

Dental Examination

Child's Name:	Today's Date:	
DIAGNOSTIC & PREVENTATIVE PROCE ☐ Clinical Exam ☐ Prophylaxis ☐ Other	☐ X-rays ☐ Fluoride Application	
GUMS & SUPPORTING TISSUE: ☐ Normal & Healthy ☐ Sligh ☐ Moderate Inflammation (gingivitis) ☐ Other:	☐ Advanced Disease (periodontitis)	
	at this time. Return in months for exam. required. Dental treatment is identified below.	
RIGHT LOWER 30 19 0	Tooth # or Letter Description of Dental Services Required	
Doctors Name:		
Address:		
Phone Number:		
Signature of Dentist	 Date	
AGEN Adult who attended appt: By signing I acknowledge I was present, understand t CW who received med form: By signing I acknowledge I received the information a	CY USE ONLYSigned: he diagnosis, medications and/or recommendationsSigned: and documented any necessary changes	