

Grade: \_\_\_\_\_  
HR: \_\_\_\_\_

Commonwealth of Pennsylvania  
Department of Health  
Dental Health  
Parkland School District  
**FAMILY DENTIST REPORT**

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Name of Child

Birthdate

Sex M ( ) F ( )

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Home Address

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The above name child last visited my office on \_\_\_\_\_ (Date).

At the time all necessary dental corrections were made. Yes ( ) No ( )

Child is currently under treatment Yes ( ) No ( )

Child has received prophylaxis Yes ( ) No ( )

With Fluoride Yes ( ) No ( )

Print Name of Dentist: \_\_\_\_\_ (D.D.S. or D.M.D.)

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_