Summit Preschool Dental Statement

(to be completed by a Dentist or Physician)

Return to: 420 Washington Ave. Cuyahoga Falls, Ohio 44221

Phone: 330-945-5600 Fax 330-945-6222

Student Full Name ______________________________ Date of Birth ______________

Date of Exam ______________________________

Please mark all diagnostic and preventive services performed during visit:

Examination	Yes	No
Cleaning	Yes	No
Fluoride	Yes	No
X-ray	Yes	No
Treatment (extractions, restoration, etc.)	Yes	No

If yes, explain

Does the child require further treatment? Yes No

If yes, next appointment date:

Does the child have any problems with his/her teeth, gums or mouth? Yes No

If yes, explain:

Name of Dentist ______________________________

Name of Practice ______________________________

Phone Number ______________________________

Street Address ______________________________

City, State, and Zip code ______________________________

Dentist or Physician Signature Date