MOTHER OF
PROVIDENCE
REGIONAL CATHOLIC SCHOOL

607 S. Providence Road, Wallingford, PA 19086
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DUE WITHIN 30 DAYS OF BEGINNING SCHOOL FOR GRADES, K, 3 AND 7 AND ALL STUDENTS NEW TO PENNSYLVANIA SCHOOLS

PRIVATE DENTIST REPORT

LAST NAME _____ FIRST _____ INITIAL _____

DOB ____/____/____ GRADE_____ SCHOOL _____

The above-name child last visited my office on ____/____/____.

At that time, all necessary dental corrections had been made ☐ YES ☐ NO

As of ____/____/____, has received topical fluoride application ☐ YES ☐ NO

PLEASE COMPLETE THE FORM BELOW

The child is in need of treatment for one or more of the following:

Primary teeth ☐ fillings ☐ extractions
Permanent teeth ☐ fillings ☐ extractions

Diseases of the supporting tissues

_____

Gross malocclusion, which is producing a facial deformity or is interfering with function

_____

Cleft palate and/or cleft lip ☐ YES ☐ NO

Other congenital malformations (specify)

_____

Prosthetic replacements for lost or missing teeth ☐ YES ☐ NO

The child is currently under treatment ☐ YES ☐ NO

_____ _____
Signature Address

(_____) _____ _____
Phone City, State, Zip