

Commonwealth of Pennsylvania
 Department of Dental Health
 FAMILY DENTIST REPORT

School District – General McLane	Erie County	School Address
Name of Child (Last) (First)	Birthdate	McKean Elementary 5120 West Road McKean Pa 16426
Home Address (Street, City, State)	Sex M__F__	

The above named child last visited my office on _____ (date).

At that time necessary dental corrections had been made. Yes___ No___

If the answer is no, fill in the following:

This 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___ Other congenital malformations___

Prosthetic replacement for lost or missing teeth _____

This child is currently under treatment Yes___ No___

Date Submitted _____ Signature _____ D.D.S.

Address _____