De Soto Area Schools
Dental Health Form

Please complete this form and return the office at your child's school.

Name of Child _____ Age _____

School _____

Grade _____

Name of Dentist _____

Dentist's Address _____

_____

Dentist's Phone number ( ) _____

1. Has your child previously been seen by a dentist?
   ____Yes
   ____No
2. Dental Needs
   ____ a. treatment
   ____ b. cleaning
   ____ c. fluoride
   ____ d. other
   ____ e. no problems
3. Child's oral health
   ____ a. routine recall visits
   ____ b. special home emphasis on oral hygiene
   ____ c. dietary problems
   ____ d. developmental problems
   ____ e. harmful oral habits
   ____ f. needs fluoride supplement

Signature of the Dentist _____

Date _____