SHREWSBURY CHRISTIAN ACADEMY

701 Windy Hill Road
New Freedom, PA 17349
Phone: 717-235-5763
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Dental History

Student Information

Student's Name ____
Last *First* *Middle*

Date of Birth ________________ Gender ☐ Male ☐ Female Grade ________

Home Address ____

Home Telephone ______________________________

Dentist's Name ______________________________ Dentist's Phone ____________

Dental Information

This section is to be completed by the child's dentist.

Date of Visit: ________________

At the time of the visit had all necessary dental corrections been made? ☐ Yes ☐ No

If no, please complete the following on treatment:

_____ Primary Teeth _____ Fillings _____ Extractions

_____ Permanent Teeth _____ Fillings _____ Extractions

_____ Disease of supporting tissues *(please describe)* ______________________

_____ Gross Malocclusion, which is producing a facial deformity or is interfering with function *(please describe)* ______________________

_____ Cleft palate and/or cleft lip *(please describe)* ______________________

_____ Other congenital malformations *(please describe)* ______________________

_____ Prosthetic replacement for lost or missing teeth *(please describe)* ______________________

____

Is the child currently under treatment? ☐ Yes ☐ No

If yes, please explain ______________________________

Has the child received topical F applications? ☐ Yes ☐ No

Please use the space provided to list any other dental conditions or concerns.

Dentist's Signature ______________________________ Date ____________

Dentist's Address ____