Lincoln Christian School

Dental Examination Report

This is to certify that I have thoroughly examined the teeth of:

_____

(Please print full name of patient)

Please Check ONE:

_____ No dental treatment is necessary at this time.

_____ All necessary dental treatment has been completed.

_____ Dental treatment is scheduled.

Further recommendations:

_____

_____

_____

_____ _____

(Date) (Signature of Dentist)

If you have any questions, please contact the Lincoln Christian School Nurse at 488-8888 x 230.