Student Dental Health Record

Student Name

Grade/Section

Date of Birth

Gender

Student ID

Date of Exam

Parent/Guardian Name

Contact Number

Dental History

Previous Dental Visits?

If Yes, Date of Last Visit

Reason for Last Visit

Any dental pain/complaints?

If Yes, describe

Clinical Findings

Teeth Present

Cavities Observed

Missing/Extracted Teeth

Gum Condition

Malocclusion

Other Findings

Oral Hygiene Assessment

Brushing Frequency (per day)

Type of Toothbrush Used

Uses Fluoride Toothpaste?

Other Oral Hygiene Practices

Dentist's Recommendations

Dentist's Name

Signature

Date