DENTAL RECORD
(To be completed by the dentist)

Columbus City Schools
Health, Family and Community Services
61 South 6th Street
Columbus Ohio 43215

Student Name_____ Date of Birth_____ School Yr_____
School_____ HR / Grade_____
Parent/ Guardian Name_____

Child was examined on _____(Date)

The following services have been performed: (*Please Check*)

- Radiographs ☐
- Oral Prophylaxis ☐
- Fluoride Treatment ☐
- Restorations ☐

The following statements are applicable: (*Please Check)*

- All necessary services have been performed ☐
- No restorative services are required at this time ☐
- The child is in treatment and future appointments have been arranged ☐

Signature _____, D.D.S.

Approved: Columbus Dental Society