



CommonSense

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CommonSenseAdoption.org

## DENTAL EXAM FOR FOSTER CARE

Date of Visit: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

This is to certify that \_\_\_\_\_ had a dental examination on \_\_\_\_\_  
(Name of Child) (Date)

Review of child's dental history: \_\_\_\_\_

\_\_\_\_\_

Examination of hard and soft tissue of oral cavity:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

X-rays for diagnostic purposes, if deemed necessary by dentist:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Dentist or Dentist Designee

\_\_\_\_\_  
Printed Name of Dentist or Designee

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone