

Dental Report

Des Moines Area Community College
2006 S. Ankeny Boulevard, Ankeny, IA 50023

Part 1: Personal Dental History (to be completed by the student):

Name (Last, First): _____

Address (Street, city, state, zip): _____

Date of last dental appointment: ____/____/____ Did you have x-rays? **YES** or **NO**

Do you have any dental discomfort at this time? **YES** or **NO**

If yes, please explain: _____

Do you make regular dental visits? **YES** or **NO**

Have you lost any teeth? **YES** or **NO** Have they been replaced? **YES** or **NO**

Check any that apply: ___ Fixed Bridge, ___ Removable Partial, ___ Denture

If yes, please explain: _____

How often do you brush your teeth? _____

Have your teeth ever been straightened? **YES** or **NO**

Part 2: Clinical Data (to be completed by a licensed dentist):

Insofar as you know are the statements correct as completed by the applicant in Part I of this form? **YES** or **NO**

If no, please state any know irregularities: _____

State general condition of teeth: _____

Inflammation of gingival tissue: ___ Moderate ___ Severe Color _____

Occlusion: _____

Any restorations needed at this time? **YES** or **NO** If yes, please explain: _____

Any further treatment needed at this time? **YES** or **NO** If yes, please explain: _____

Signature of dentist: _____ Date of exam: ____/____/____

Address (Street, city, state, zip): _____

Phone Number: ____ - ____ - ____