



Family Works

5604 Medical Circle
Madison, Wisconsin 53719

ORAL EXAMINATION FORM

Name_____	Dentist_____
Date of Birth_____	Clinic Name_____
Foster Parents_____	Address_____
Address_____	Phone_____
Phone_____	Examination Date_____
Social Worker_____	Submission Date_____

Dental History

Current Medical Treatment:

Medical:

Disease_____

Allergies_____

Heart-Lung_____

Surgery_____

Occlusion:

Classification_____

Eruption Schedule_____

Anterior Alignment_____

Reaction_____

Muscular attachments_____

Fluoride_____

Remarks:

Signature of Dentist _____

Thank you for your assistance.