BERKS COUNTY CHILDREN & YOUTH SERVICES
DENTAL REPORT

CLIENT_____________________________________ DOB_____________ DATE_____________

_______ Examination

_______ X-rays

_______ Topical Flouride Application

_______ Fillings

_______ Extractions

_______ Disease of Supporting Tissue

_______ Malocclusion

_______ Dental Work in Progress

_______ Dental Work Completed

____ ____
Dentist's Signature Date

Address: ____

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Phone: ____