foundations
health & wholeness

Dental Exam & Teeth Cleaning

(to be completed **every 6 months**)

Foster Child: _____ DOB: _____

Date of Exam: _____

A. Teeth

☐ Good ☐ Fair ☐ Poor

Number of Cavities: _____

B. Gums

☐ Normal ☐ Inflamed

C. Recommendations

_____

_____

_____

_____ _____

Provider Name Phone

_____

Address City Zip

_____

Provider Signature