



# Blue Mountain Academy

## Dental Examination Record

The following information is to be completed by a dentist. Please return this form directly to:  
Blue Mountain Academy, Health Services, 2363 Mountain Road, Hamburg, PA 19526.

***Student should have all necessary work done prior to admission.***

Student's Name (Print or Type)	Social Security #	Birth Date	Grade
Home Address	Phone ( )		
Street Address	City	State	Zip

### UPPER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
[Upper Teeth Diagrams 1-8]								[Upper Teeth Diagrams 9-16]							

### LOWER

Date of Examination: \_\_\_\_\_ Requires Treatment?  Yes  No

Indicate Treatment: \_\_\_\_\_

Wearing Braces?  Yes  No If Yes, Plan of Treatment? \_\_\_\_\_

Orthodontist's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Dentist's Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

Dentist's Address: \_\_\_\_\_