



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 dental check-up prior to admission.

Student's Name (Print) _____ Birth Date _____ Current Grade _____

Home Address _____ City _____ State _____ Zip _____ Home Phone _____

UPPER

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

LOWER

Date of Examination: _____

Does the student require dental treatment? Yes No

If yes, indicate treatment: _____

Does the student wear braces? Yes No

Orthodontist's Name: _____

Orthodontist's Phone: _____

Dentist's Signature: _____

Dentist's Name (Print) _____

Dentist's Address: _____

Dentist's Phone: _____