MARIEMONT City Schools
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Mariemont City Schools | 2 Warrior Way | Cincinnati, OH 45227 | www.mariemontschools.org | Office 513-272-7500 | Fax 513-527-3436

DENTIST'S REPORT

Date of Exam: _____

Student's Name: _____

The following services have been performed:

_____ radiographs
_____ fluoride treatment
_____ oral prophyaxis
_____ restorations

The following statements are applicable:

_____ All necessary services have been performed.
_____ No restorative services are required at this time.
_____ Further treatment if indicated.
_____ Future appointments have been arranged.

Comments:

Signature of Dentist: _____

Name of Dental Practice: _____