



St. Catherine  
Early Childhood Education Center  
Dental Form  
2020-2021



1. Student Information

|                                 |
|---------------------------------|
| Student Name _____              |
| Address _____ Birthdate _____   |
| Parent/Guardian's Name(s) _____ |

2. Dental Treatment (Mark for treatment actually done)

|   |
|---|
| <input type="checkbox"/> Dental Prophylaxis (cleanings) |
| <input type="checkbox"/> Restorations                   |
| <input type="checkbox"/> Extractions                    |
| <input type="checkbox"/> Other _____                    |

3. Dentist Information

|   |             |                |  |
|---|-------------|----------------|--|
| In the event of a dental emergency, please contact the following dentist: |             |                |  |
| Dentist Name _____  |             |                |  |
| Address _____   |             |                |  |
| City _____  | State _____ | Zip Code _____ |  |
| Phone Number _____  |             |                |  |

