

Children's Dental Examination Report

(Needs to be completed by applicant's dentist)

Please present this form to your treating/examining dentist for completion. A parent, sibling or relative of the child may not carry out the examination. Costs of the examination and reports are to be paid by the applicant's parent/legal guardian.

Instructions to treating/examining dentist

Detailed dental examination is required in order that all questions listed below can be answered. If there are many „Yes“ responses to the questions listed below, or if otherwise clinically indicated, bitewing and panoramic (or diagnostic quality full mouth) radiographs should be performed. Please send the current and any previous x-ray reports together with this form.

I. Details of insured person (to be filled in by the applicant)

Name of policyholder			
Policy No.			
Name of insured child (patient)			
Date of birth		Sex	

II. Dental findings (to be filled in by the treating/examining dentist)

1. When did the child last receive a dental treatment in your dental office or by a previous dentist?			Previous dentist			
2. Did the child receive regular examinations or check-ups in the past three years?			☐ Yes	☐ No		
3. Have any dental x-rays been taken in the past or during this examination?			☐ Yes	☐ No		
If "Yes", please describe the nature and indication of the x-rays, mention the dates and send the previous and current x-rays to Foyer Global Health S.A.			Previous dentist(s)			
4. Who carried out the treatments/ examinations in the past three years? Name of current and previous dentist(s)/address/ e-mail/telephone number.			Previous dentist(s) (may be filled in by the applicant)			
5. Present dental findings	right 55 54 53 52 51 A B C D E T S R Q P 85 84 83 82 81 Upper 61 62 63 64 65 F G H I J O N M L K 71 72 73 74 75 Lower left FDI FDI					

6. Is there an untreated caries, pit and fissure cavitated lesion, insufficient filling/sealant, chipped or broken tooth that requires restoration or extraction? ☐ Yes ☐ No

If yes, which tooth/teeth?

7. Is there an existing root abscess/apical periodontitis or cyst that requires a root canal treatment, pulpotomy, amputation, extraction or is or is further referral of the patient necessary or advisable? ☐ Yes ☐ No

If yes, which tooth/teeth?

8. Does the child clench or grind the teeth or has any other habits? ☐ Yes ☐ No

If yes, please use the section 15 for further details.

9. Is there a history of cleft lip or cleft palate? ☐ Yes ☐ No

If yes, please use the section 15 for further details.

10. Is there a hyperdontia, hypodontia or anodontia? ☐ Yes ☐ No

If yes, please use the section 15 for further details.

11. Does the child have a malocclusion? Is there a history of orthodontic treatment, presently undergoing active orthodontic treatment or wearing retainer appliances? ☐ Yes ☐ No

If yes, please use the section 15 for further details.

12. Please indicate on the chart the necessary and recommended restorations:

F = Filling

S = Sealant

K = Crown

P = Pulpotomy

X = Extraction

Upper											
right	55	54	53	52	51	61	62	63	64	65	left
	A	B	C	D	E	F	G	H	I	J	FDI
	T	S	R	Q	P	O	N	M	L	K	FDI
	85	84	83	82	81	71	72	73	74	75	
Lower											

13. Is there an orthodontic treatment necessary or recommended or may need treatment in the future? ☐ Yes ☐ No

14. Is there an urgent treatment necessary or recommended (abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling)? ☐ Yes ☐ No
If yes, please also use the section 15 for further details.

15. Other abnormalities, observations, remarks or necessary/recommended and planned treatments not previously mentioned (please specify).

Place and date of today's examination

(please sign and stamp)

Stamp

Signature of the treating/examining dentist with stamp and date