College of Eastern Idaho
Health Professions Division
Dental Assisting Program Dental Examination Form

Student's Name: _____ Phone #: _____
Alternate Phone: _____ Email: _____
Address: _____ City: _____ State: _____ Zip: _____
Dentist's Name: _____ Office Phone#: _____
Address: _____ City: _____ State: _____ Zip: _____

Is any dental treatment needed at this time? Yes: _____ No: _____
Explain briefly what type:

_____
_____
_____
_____

Please describe the general condition of the student's oral cavity: _____

_____
_____
_____

In your opinion, what is the attitude of this person regarding the health and care of the oral cavity? _____
_____
_____

The above student can have x-rays taken at CEI Dental Assisting Clinic as part of the Dental Assisting Program?
Yes: ☐ No: ☐

The above student can have their teeth bleached /whitened at CEI Dental Assisting Clinic as part of the Dental Assisting Program? Yes: _____ No: _____

Dentist Signature: _____ Date: _____