

OCCUPATIONAL THERAPY ASSISTANT PROGRAM

PRE-ENTRANCE DENTAL RECORD

Name: _____

This is to certify that the above named applicant completed a dental examination on:

(Date)

I found his/her teeth and gums are currently:

_____ In good health _____ In need of treatment

Please describe the treatment needed:

Could the condition of this person's oral health in any way affect his/her general health?

_____ No _____ Yes

If YES, please explain:

(Signature of Dentist) (Date) (Phone)

(Address) (City) (State) (Zip)

PLEASE MAIL THIS FORM TO:

**OCCUPATIONAL THERAPY ASSISTANT PROGRAM
GROSSMONT COLLEGE
8800 Grossmont College Drive
El Cajon, CA 92020**

Please affix business
card or office stamp here.