



11400 Robinwood Drive • Hagerstown, Maryland 21742-6590 • (240) 500-2000

Dental Hygiene

HCC Student Name: _____ HCC Student ID #: _____

Student Birth date: ____/____/____

Student street Address: _____

City: _____ State: _____ Zip: _____

Dentist's Name: _____ Dentist's Phone #: _____

The following to be filled out by Examining Dentist ONLY

Prophylaxis: Date of Last _____ Radiographs: Date Taken: _____

Gingiva: Healthy _____ Inflamed _____

Periodontal Health: Healthy _____ Periodontal Disease Present _____

Hard Tissue Exam: Tooth Anatomy/Restorative work in tact with no concerns _____ Yes / _____ No

Soft Tissue Exam: Healthy/Normal _____ Areas of Concern: _____

Caries Present: Yes _____ No _____

Home Care: Good _____ Poor _____

Please specify any conditions listed above that would hinder the student from participating as a student/partner patient within the Dental Hygiene Program at Hagerstown Community College.

Place a check in space below where applicable:

_____ Student requires no dental treatment at this time.

_____ Student is under the care of Dentist to complete necessary treatment to return oral cavity to a state of health.

_____ Student is NOT cleared to participate in HCC Dental Hygiene Pre-clinic partner patient pairs.

Examining Dentist Signature: _____ Date: _____