RADIATION AND PUBLIC HEALTH

radiation.org/tooth-donation-form/

Tooth Donation Form
Please fill out the following form and send it with your baby teeth to: Radiation and Public Health, P.O. Box 1260, Ocean City NJ 08226.
Thanks for helping!

Mother: _____
First Last

Phone: _____ **Email:** _____
Area Code Phone Number

Address: _____
Street

_____
City State County Zip

Child's Name: _____
First Last

Birth Date: _____ **Birthweight:** _____
Month Day Year Pounds Ounces

Sex: Female ____ Male ____

Residence when mother was pregnant:

_____
City State County Zip

Residence where child was born:

_____
City State County Zip

Residence during first year of life:

_____
City State County Zip

Mother's Date of Birth: _____
Month Day Year

Mother's place of birth:

_____
City State County Zip

Does the child have a long-term health problem? Yes ____ No ____

If the answer is yes, please explain (all answers will be kept confidential)

_____

_____

_____

Water source: (from well, municipal water, bottled water, or?):

_____