Ohio Department of Health • School and Adolescent Health Oral Assessment

Student's name				Date of birt	th		
					/	/	
The following services have been	en performed (please check a	ll that apply)					
☐ Examination	☐ Fluoride application	☐ Oral prophylaxis (cleaning)	☐ Pr	☐ Prescription for fluoride supplement☐ Treatment (restoration, pulp therapy)			
Orthodontic assessment	Radiographs	☐ Dental sealant					
Other							
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The following oral hygiene inst	ruction was provided (pleas	e check all that apply)					
☐ Toothbrushing	☐ Flossing	☐ Dietary counseling		Use of fluoride mouthrinse			
Other							
The following statements are a	pplicable (please check all that	t apply)					
All necessary preventive services No restorative services are requi Further treatment is indicated.(S Further appointments have beer Routine recall visits recommende	red at this time. See comments) n arranged. (Orthodontic, restor					·	
						· ************************************	
		•					
Dentist's signature	P	rint name		Phone			
Address •			-	Date-			
					/	/	
City			State	ZIP '			