

# Ohio Department of Health • School and Adolescent Health

## Oral Assessment

Student's name	Date of birth / /
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**The following services have been performed** (please check all that apply)

<input type="checkbox"/> Examination	<input type="checkbox"/> Fluoride application	<input type="checkbox"/> Oral prophylaxis (cleaning)	<input type="checkbox"/> Prescription for fluoride supplement
<input type="checkbox"/> Orthodontic assessment	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Dental sealant	<input type="checkbox"/> Treatment (restoration, pulp therapy)
<input type="checkbox"/> Other _____			

**The following oral hygiene instruction was provided** (please check all that apply)

<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dietary counseling	<input type="checkbox"/> Use of fluoride mouthrinse
<input type="checkbox"/> Other _____			

**The following statements are applicable** (please check all that apply)

<input type="checkbox"/> All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
<input type="checkbox"/> No restorative services are required at this time.
<input type="checkbox"/> Further treatment is indicated.(See comments)
<input type="checkbox"/> Further appointments have been arranged. (Orthodontic, restorative)
<input type="checkbox"/> Routine recall visits recommended.

Comments

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Dentist's signature	Print name	Phone (      )
Address		Date / /
City	State	ZIP