

Ohio Department of Health • School and Adolescent Health
Oral Assessment

Student's name	Date of birth / /
----------------	----------------------

The following services have been performed (please check all that apply)

☐ Examination	☐ Fluoride application	☐ Oral prophylaxis (cleaning)	☐ Prescription for fluoride supplement
☐ Orthodontic assessment	☐ Radiographs	☐ Dental sealant	☐ Treatment (restoration, pulp therapy)
☐ Other _____			

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

☐ Toothbrushing	☐ Flossing	☐ Dietary counseling	☐ Use of fluoride mouthrinse
☐ Other _____			

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

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated. (See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.
Comments _____ _____ _____ _____

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