Ohio Department of Health • School and Adolescent Health Oral Assessment

Student's name			Date of birth
			1 1
The following services have bee	en performed (please check all	that apply)	
☐ Examination ☐ Orthodontic assessment ☐ Other	☐ Fluoride application☐ Radiographs	☐ Oral prophylaxis (cleaning) ☐ Dental sealant	☐ Prescription for fluoride supplement ☐ Treatment (restoration, pulp therapy)
The following oral hyglene inst	ruction was provided (please	check all that apply)	
☐ Toothbrushing ☐ Other	☐ Flossing	☐ Dietary counseling	Use of fluoride mouthrinse
The following statements are a	pplicable (please check all that a	apply)	
All necessary preventive services No restorative services are requi Further treatment is indicated.(5 Further appointments have been Routine recall visits recommend	ired at this time. See comments) n arranged. (Orthodontic, restoral		
Dentist's signature	Pr	rint name	Phone ()
Address		**************************************	Date / /
City			State ZiP