Ohio Department of Health • School and Adolescent Health Oral Assessment

Student's name				Date of birth		
				/	/	
The following services have been	-					
Examination	Fluoride application	Oral prophylaxis (cleaning)		Prescription for fluoride supplement		
Orthodontic assessment	Radiographs	☐ Dental sealant	☐ Tre	☐ Treatment (restoration, pulp therapy)		
Other						
The following oral hygiene inst	ruction was provided (please	check all that apply)				
☐ Toothbrushing	☐ Flossing	☐ Dietary counseling	Use of fluoride mouthrinse			
Other	_	,				
The following statements are a	pplicable (please check all that	apply)				
☐ All necessary preventive services	have been performed. (Fluoride	treatment, prophylaxis)				
No restorative services are requi	red at this time.					
Further treatment is indicated.(S						
Further appointments have been Routine recall visits recommend	=	tive)				
Comments	eu. 					
Confinents						
Dentist's signature	Pi	rint name		Phone		
Address				Date		
				/	/	
City			State	ZIP		