Ohio Department of Health • School and Adolescent Health Oral Assessment

Student's name			Da	ite of birth	/	/	
The following services have bee	n 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 hygiene instr	ruction was provided (ple	ase check all that apply)					
☐ Toothbrushing ☐ Other	Flossing	☐ Dietary counseling	☐ Use o	Use of fluoride mouthrinse			
The following statements are ap All necessary preventive services No restorative services are requirative. Further treatment is indicated.(S Further appointments have beer Routine recall visits recommended. Comments	have been performed. (Fluoring at this time. see comments) a raranged. (Orthodontic, rest	de treatment, prophylaxis)					
Dentist's signature		Print name		Phone ()		
Address			1	Date	/	/	
City			State 2	ZIP			