Ohio Department of Health • School and Adolescent Health Oral Assessment

Student's name			Date of birth	
			/ /	
The following services have bee		· · · · · · · · · · · · · · · · · · ·		
☐ Examination ☐ Orthodontic assessment	☐ Fluoride application ☐ Radiographs	☐ Oral prophylaxis (cleaning)☐ Dental sealant	Prescription for fluoride supplement	
Other	□ kadiographs	□ Dentai sealant	☐ 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 a	nalv)		
☐ All necessary preventive services ☐ No restorative services are requ ☐ Further treatment is indicated.(☐ Further appointments have bee ☐ Routine recall visits recommend	ired at this time. See comments) n arranged. (Orthodontic, restorat			
Dentist's signature	Pr	int name	Phone (
Address			Date / /	
			1 /	