

# Norwood City Schools

## Ohio School History

### Dentist Assessment

School: \_\_\_\_\_

ENROLLED: \_\_\_\_\_

#### ORAL ASSESSMENT

Child's Name: \_\_\_\_\_ Gender:  M or  F Age: \_\_\_\_\_ DOB: \_\_\_\_\_

#### Ethnicity:

Caucasian  African American  Hispanic  Asian American  Other

#### The following services have been performed:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Examination by Dentist      | <input type="checkbox"/> Orthodontic Assessment | <input type="checkbox"/> Oral Screening              |
| <input type="checkbox"/> Dental Sealants             | <input type="checkbox"/> Radiographs            | <input type="checkbox"/> Fluoride Application        |
| <input type="checkbox"/> Oral Prophylaxis (cleaning) | <input type="checkbox"/> Diagnosis              | <input type="checkbox"/> Rx for fluoride supplements |

#### The following oral hygiene instruction was provided:

- |   |   |
|---|---|
| <input type="checkbox"/> Brushing teeth | <input type="checkbox"/> Diet counseling related to dental health |
| <input type="checkbox"/> Flossing       | <input type="checkbox"/> Home/school use of fluoride mouth rinse  |

#### The following statements are applicable:

- No apparent care needed at this time.
- All necessary preventative 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. (ex. Orthodontic, restorative)

#### Comments:

Examiner's Signature: \_\_\_\_\_ Date signed: \_\_\_\_\_

Examiner's Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_