



Pre-School (circle one)

Ohio School History
Dental Assessment

Sharpsburg - Williams
Enrolled: _____

ORAL ASSESSMENT

Child's Name: _____ Gender: <input type="checkbox"/> M or <input type="checkbox"/> F Age: ____ DOB: _____
Ethnicity: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian American <input type="checkbox"/> 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: _____