The Northeastern Local School District
Preparing students for their NExt success!

Superintendent	Dr. John Kronour
Treasurer	Mr. Dale Miller
Assistant Superintendent	Mr. Shawn Blazer
Director of Pupil Personnel	Mr. Steve Linson

Northeastern Local School District Preschool Program-Dental Form

Exam Date: ___/___/____ **Child's Name:** _____ **Birth date:** _____
School: _____

Exam Completed by: ☐ DMD ☐ RDH ☐ Other: Specify _____

Provider Setting: ☐ Doctor/Dentist/Clinic ☐ School/Center ☐ Other: Specify _____

Evaluation Type: ☐ Screening ☐ Exam

Flossing Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of Times per Day Child Brushes Teeth: _____

Uses Fluoride Toothpaste: ☐ Yes ☐ No **Takes Fluoride Supplement:** ☐ Yes ☐ No

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

General Comments on Oral Health: _____

Today's Visit:

- ☐ Visual Screening
- ☐ Full Exam
- ☐ X-Rays
- ☐ Cleaning
- ☐ Fluoride Treatment
- ☐ Oral Hygiene Instruction
- ☐ Treatment (specify)

_____
_____
_____
_____
_____

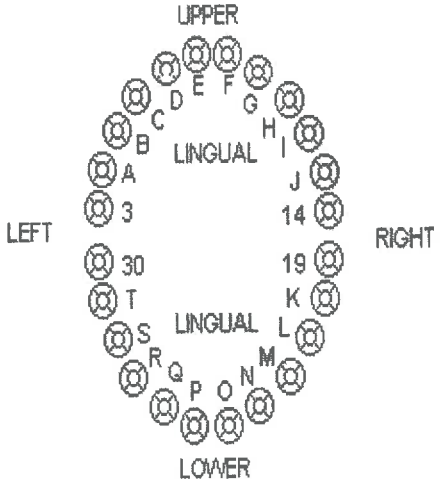
Treatment:

- ☐ No Needs
- ☐ Treatment Needed

Next Appointment Date:
_____/_____/_____

Treatment Plan:

_____
_____
_____
_____
_____



Key: Missing Decayed Filled

Provider Signature: _____ **Exam Completion Date:** ___/___/____
Printed or Stamped Name/Address of Provider: _____
Address: _____ **Phone:** _____