ORWOOD CITY SCHOOL DISTRICT 2023-24

Pre-School & Kindergarten

Ohio School History

Dental Assessment

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:

☐ Examination by Dentist	☐ Orthodontic Assessment	☐ Oral Screening
☐ Dental Sealants	☐ Radiographs	☐ Fluoride Application
☐ Oral Prophylaxis (cleaning)	☐ Diagnosis	☐ Rx for fluoride supplements

The following oral hygiene instruction was provided:

☐ Brushing teeth	☐ Diet counseling related to dental health
☐ Flossing	☐ 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: _____________________________

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