River Valley Local Schools Preschool
Dental Assessment Form

Child's Name: ______________________________ Date of Birth: ______________

School: ______________________________

Exam Completed by: ____ DMD ____RDH ____ Other (specify): ________

Provider Setting: ____ Doctor/Dentist/Clinic _____ School Center _____Other (specify): ________

Evaluation Type: ____ Screening. _____ Exam

-To Be Completed By Parent-

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:

____

If child is not being seen by dentist:

____ I want my child to be seen by a dentist by need more information

____ I do not want my child to be seen by a dentist

Parent Signature: ______________________________

Local Dentists:

- Marion Dental Associates: 740-387-4804
- Finney Family Dentistry: 740-382-5535
- Aspect Dental: 740-223-1100
- Marion Family Dental: 740-387-5188
- Marion Smile Dental: 740-387-5196

Today's Visit:
- Visual Screening
- Full Exam
- X-rays
- Cleaning
- Fluoride Treatment
- Oral Hygiene Instruction
- Treatment:

  ____

Treatment:
- No Needs
- Treatment Needed

Next Appointment:

____

Treatment Plan:

____

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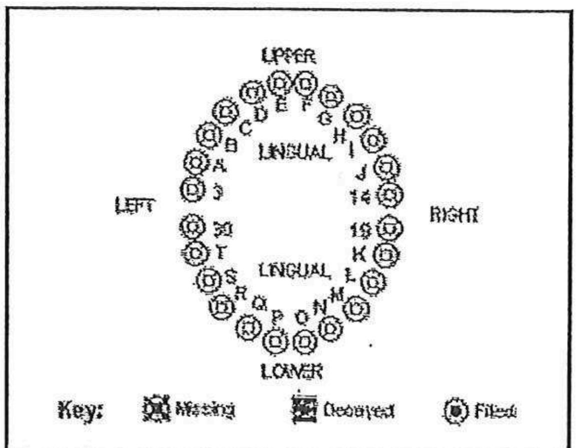

Dental Professional's Signature: ______________________________ Exam Date: ____________

Printed Name: ______________________________ Phone Number: ______________________________

Address of Provider:

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