Berea City 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 but need more information. *Danae*

☐ I do NOT want my child to be seen by a dentist at this time.

Some Local Dentist Names:

Willenberg, Middleburg Hts 440-888-6300
Arlene Coloma, Strongsville 440-526-2350
Theresa M. Bonamer, Strongsville 440-572-5437
James L. Kozik, Metro Health 216-778-7800

Parent Signature: _____ Date: _____

Today's Visit:

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

_____
_____
_____
_____
_____

Treatment:

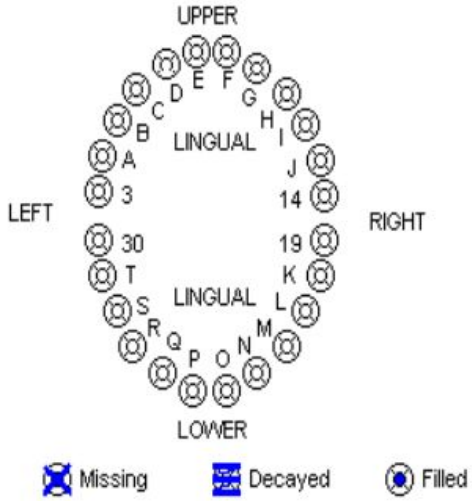
☐ No Needs
☐ Treatment Needed

Next Appointment:

_____/_____/_____

Treatment Plan:

_____
_____
_____
_____
_____



Dental Professional's Signature: _____ Examination Date: _____/____/_____

Printed or Stamped Name: _____ Phone Number: _____

Address of Provider: _____