WESTLAKE EARLY CHILDHOOD PROGRAM
SCHOOL ENTRANCE ORAL ASSESSMENT RECORD
TAKE THIS FORM TO YOUR DENTIST COMPLETE

Office Use:
Center Based / Itinerant
Docs_______________
Case Mgr__________
Clinic ______________

STUDENT NAME________________________ DATE OF BIRTH _____________GENDER M / F

DATE OF EXAM ________________________

The following services have been performed – Check ALL that apply:

Examination	☐	Fluoride application	☐	Oral prophylaxis (cleaning)	☐	Prescription for fluoride supplement	☐	Other
Orthodontic Assessment	☐	Radiographs	☐	Dental Sealant	☐	Treatment (restoration, pulp therapy	☐	

The following oral hygiene instruction was provided – Check ALL that apply:

Tooth brushing	☐	Flossing	☐	Dietary counseling	☐	Use of fluoride mouth rinse	☐	Other

The following statements are applicable – Check ALL that apply:

☐	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. (Orthodontic, restorative)
☐	Routine recall visits recommended
	Comments

Dentist's Name (Please Print):______________________ Dentist's Signature ___________________________