



The Northeastern Local School District

Preparing students for their NExT success!

Superintendent Mr. Jack Fisher
Treasurer Mr. Dale Miller
Assistant Superintendent Mr. Shawn Blazer
Director of Pupil Services Mr. Steve Linson

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
- ☐ Treatment (specify)

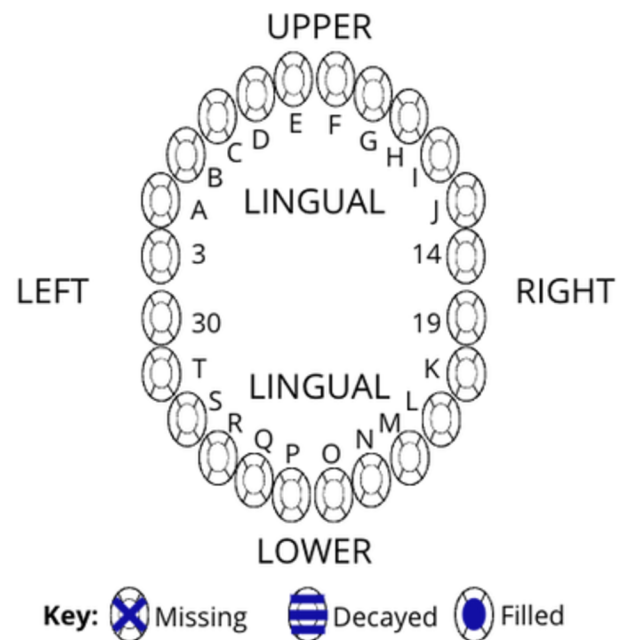
Treatment:

- ☐ No Needs
- ☐ Treatment Needed

Next Appointment Date:

____/____/____

Treatment Plan:



Provider Signature: _____ Exam Completion Date: ____/____/____

Printed or Stamped Name/Address of Provider: _____

Address: _____ Phone: _____