



Clark County Educational Service Center
 4170 Allium Ct.
 Springfield, Ohio 45505
 Phone: 937-325-7671 Fax: 937-717-0518



PRESCHOOL ORAL HEALTH ASSESSMENT

Name of Child: _____ Date of Birth: _____

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

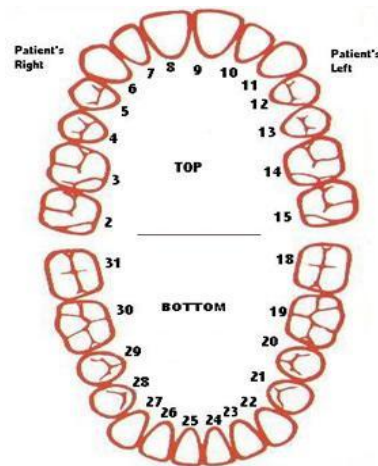
Number of time per day child brushes teeth: _____

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	Treatment
<input type="checkbox"/> Visual Screening	<input type="checkbox"/> No needs
<input type="checkbox"/> Full Exam	<input type="checkbox"/> Treatment needed
<input type="checkbox"/> X-Rays	Treatment plan:
<input type="checkbox"/> Cleaning	_____
<input type="checkbox"/> Fluoride Treatment	_____
<input type="checkbox"/> Hygiene Instruction	_____
<input type="checkbox"/> Treatment (specify)	Next Appointment Date:



KEY

Missing- M

Decayed- D

Filled-F

Provider Signature _____ Date of Exam _____

Printed or stamped Name of Provider _____

Address _____ Phone _____