**Ohio Department of Health • School and Adolescent Health**

**Oral Assessment**

<table>
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<tr>
<th>Student's name</th>
<th>Date of birth</th>
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**The following services have been performed** (please check all that apply)

- [ ] Examination
- [ ] Fluoride application
- [ ] Oral prophylaxis (cleaning)
- [ ] Prescription for fluoride supplement
- [ ] Orthodontic assessment
- [ ] Radiographs
- [ ] Dental sealant
- [ ] Treatment (restoration, pulp therapy)
- [ ] Other

**The following oral hygiene instruction was provided** (please check all that apply)

- [ ] Toothbrushing
- [ ] Flossing
- [ ] Dietary counseling
- [ ] Use of fluoride mouthrinse
- [ ] Other

**The following statements are applicable** (please check all that apply)

- [ ] All necessary preventive 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**

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**Dentist's signature**  
**Print name**  
**Phone** ( )

**Address**  
**Date** / /

**City**  
**State**  
**ZIP**