REPORT OF ORAL EXAMINATION

Student's Name	Gender ❑ Male ❑ Female	Date of Birth

SERVICES PERFORMED (Check all that apply.)

❑ Examination ❑ Fluoride application ❑ Oral prophylaxis (cleaning) ❑ Prescription for fluoride supplement

❑ Dental sealant ❑ Radiographs ❑ Orthodontic assessment ❑ Treatment (restoration, pulp therapy)

❑ Other_____

ORAL HYGIENE INSTRUCTION (Check all that apply.)

❑ Tooth brushing ❑ Flossing ❑ Dietary counseling ❑ Use of fluoride mouth rinse

❑ Other_____

HEALTH STATEMENTS (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

DENTIST'S INFORMATION

Date	Print Name	Phone

Dentist's Signature

Fax completed form to: ATTN: Records at 844-865-4124 or Mail to: 3650 B Sunbury Rd., Columbus, Ohio, 43219