Shelby City Schools
Oral Assessment

Student's Name	Date of Birth

The following services have been performed (please check all that apply)

__ Examination __ Fluoride application __ Oral prophylaxis (cleaning) __ Prescription for fluoride supplement
__ Orthodontic assessment __ Radiography __ 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).
__ Routine recall visits recommended.

Comments:

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Dentist's signature	Print Name	Phone
Address		Date
City	State	Zip