

# Student Oral Health Form

Child's Name (Last, First, MI)

Date of Birth (MM/DD/YYYY)

Age

Address

City

State

Zip Code

Guardian

Phone

Please provide date of service in applicable box below:

School Entry

2nd Grade

7th Grade

12th Grade

Date of service

Current Oral Health Services:

Type of Services Provided?  Examination

Does the child have any teeth with untreated decay?  Yes (decay)  No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions?  Yes  No

Are there treatment needs?  Yes, urgent  Yes, not urgent  No treatment needs

Provider Name (please print)

Phone Number

Fax Number

Practice Name

Address

Provider Signature

Office Contact email