Student Oral Health Form

Patient Information

Child's Name (Last, First, MI) _____ Date of Birth (MM/DD/YYYY) _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Guardian _____ Phone _____

Oral Health Service

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

Additional Information

_____

_____

_____

_____

Oral Health Provider's Contact Information and Signature

Provider Name (please print) _____ Phone Number _____ Fax Number _____

Practice Name _____ Address _____

Provider Signature _____ Office Contact email _____