

# 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:

Date of service

School Entry

2nd Grade

7th Grade

12th Grade

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