

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

