

SAMPLE FORM

This form may be used or a similar form from your dentist's office.
Must be signed and dated by dentist within the last 365 days.

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	<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	