**ST. PIUS X SCHOOL**
**DENTAL EXAMINATION/ASSESSMENT**

| **Student's Name Last First** | **MI** | **Male Female** | **Date of Birth (M/D/Y)** |
|---|---|---|---|
| | | ☐ ☐ | / / |
| **Parents/Guardian** | **Grade** | | **Date of Exam** |
| | | | / / |

**The following services have been performed (please check all that apply):**

☐ Examination
☐ Fluoride application
☐ Oral prophylaxis (cleaning)
☐ Prescription for fluoride supplement
☐ Orthodontic assessment
☐ Radiographs
☐ Dental sealant
☐ Treatment (restoration, pulp therapy)
☐ Other: _____

**The following oral hygiene instruction was provided (please check all that apply):**

☐ Tooth brushing
☐ Flossing
☐ Dietary counseling (relative to dental health)
☐ Use of fluoride mouthrinse
☐ Other: _____

**The following statements are applicable (please check all that apply):**

☐ All necessary preventative services have been performed (fluoride treatment, prophylaxis)
☐ NO restorative services are required at this time
☐ Further treatment is indicated (see comments)
☐ Further appointments have been arranged (Orthodontic, restorative)
☐ Routine recall visits recommended

**Comments:**

_____

_____

_____

| **Dentist name (printed or stamped)** | | | **Phone** |
|---|---|---|---|
| **Address** | **City** | **State** | **Zip** |
| **Dentist Signature** | | | **Date** |