REPORT OF ORAL EXAMATION by DENTIST

Student name:	Gender:	DOB:	Date of Service:

SERVICES PERFORMED

☐Fluoride application ☐Dental sealant
☐Radiographs ☐Orthodontic assessments
☐Treatment/restoration/pulp therapy etc. (please specify in comments)
☐Other

HEALTH STATEMENTS

☐All necessary preventative services have been performed.
☐No restorative services required at this time.
☐Further appointments have been arranged.
☐Further treatment indicated (please specify in comments).

Comments on oral health:

DENTIST INFORMATION

Dentist Signature:	Printed Name:
Office Name or Stamp:	Phone Number: