Student Enrollment Center
115 S. Ludlow St. Dayton, Ohio 45402
Telephone: 937-542-5555 Fax: 937-542-3202

Dayton Public Schools Preschool Program

Title 1 ECE, ECIP, Montessori

Dental Form

Exam Date: ___/___/____ **Child's Name:** _____ **Birth date:** _____
School: _____

Exam Completed by: ☐ DMD ☐ RDH ☐ Other: Specify _____

Provider Setting: ☐ Doctor/Dentist/Clinic ☐ School/Center ☐ Other: Specify _____

Evaluation Type: ☐ Screening ☐ Exam

Flossing Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of Times per Day Child Brushes Teeth: _____

Uses Fluoride Toothpaste: ☐ Yes ☐ No **Takes Fluoride Supplement:** ☐ Yes ☐ No

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

General Comments on Oral Health: _____

Today's Visit:

- ☐ Visual Screening
- ☐ Full Exam
- ☐ X-Rays
- ☐ Cleaning
- ☐ Fluoride Treatment
- ☐ Oral Hygiene Instruction
- ☐ Treatment (specify)

_____
_____
_____
_____
_____

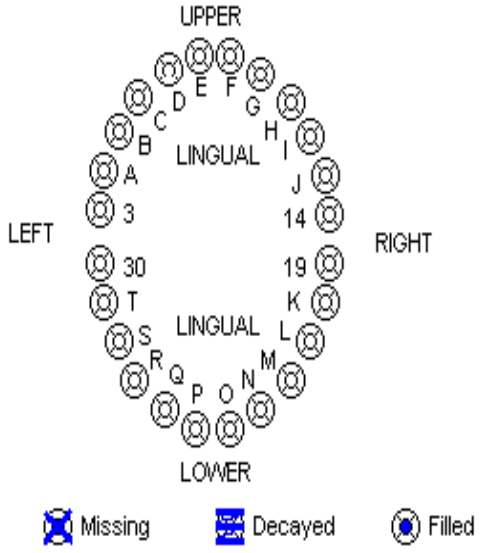
Treatment:

- ☐ No Needs
- ☐ Treatment Needed

Next Appointment Date:
_____/_____/_____

Treatment Plan:

_____
_____
_____
_____
_____



Provider Signature: _____ **Exam Completion Date:** ____/____/_____

Printed or Stamped Name/Address of Provider: _____

Address: _____ **Phone:** _____