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: ____________________