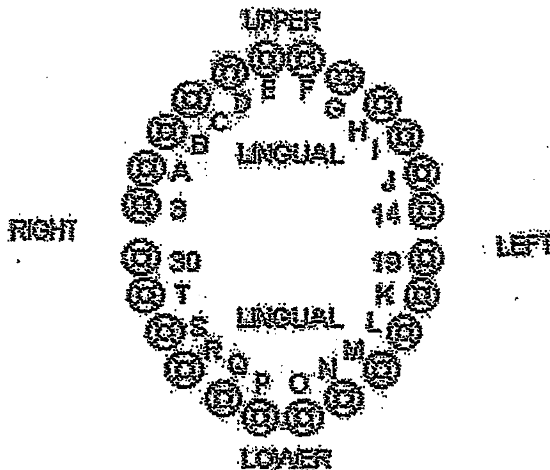
Child Oral Health Assessment

Name: ______________________________ DOB ______________

Completed by: ______________________________ (Agency Name)

Dentist/Clinic Name: ______________________________

Exam Date ______________



Key: Missing Decayed Filled

Gum Condition:

☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

Preventative Care Received:

☐ Fluoride ☐ Cleaning ☐ Sealant ☐ Other

Dental Needs:

☐ No Needs

Needs treatment: ☐

☐ Fillings ☐ Caps/Crown ☐ Pulp Therapy ☐ Restoration ☐ Extraction
☐ Surgery ☐ Other ______________________

Treatment Received ☐

☐ Fillings ☐ Caps/Crown ☐ Pulp Therapy ☐ Restoration ☐ Extraction
☐ Surgery ☐ Other ______________________

Comments: ______________________________

Next Appointment Date ______________ Time ______________

Dentist Signature: ______________________ Date ______________

Print Dentist Name: ______________________

Revised 2013