# Student Oral Health Form

CABELL COUNTY SCHOOLS

## Patient Information

Child's Name (Last, First, MI) _____ Date of Birth (MM/DD/YYYY) _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Guardian_____Phone_____

## Oral Health Service

Please provide date of service in applicable box below:

| | School Entry | 2nd Grade | 7th Grade | 12th Grade |
|---|---|---|---|---|
| Date of Service | | | | |

Current Oral Health Services:

Type of Services Provided? ☐ Examination

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

## Additional Information

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## Oral Health Provider's Contact Information and Signature

Provider Name (please print) _____ Phone Number _____ Fax Number _____

Practice Name _____ Address _____

Provider Signature _____ Office Contact Email _____