



## Head Start Oral Health Form—Children

### Patient Information

Child's name \_\_\_\_\_ Date of birth \_\_\_\_\_ Parent's/guardian's name \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

This practice is the child's dental home:  Yes  No

### Current Oral Health Status

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

### Oral Health Care Services Delivered During Visit

#### Diagnostic/Preventive Services

Examination:  Yes  No

X-rays:  Yes  No

Risk assessment:  Yes  No

Cleaning:  Yes  No

Fluoride varnish:  Yes  No

Dental sealants:  Yes  No

#### Counseling/Anticipatory Guidance

Yes  No

#### Referral to Specialty Care

Yes  No

\_\_\_\_\_  
(Please specify specialist)

#### Restorative/Emergency Care

Fillings:  Yes  No

Crowns:  Yes  No

Extractions:  Yes  No

Emergency care:  Yes  No

Other: \_\_\_\_\_  
(Please specify)

### Future Oral Health Care Services

All treatment completed:  Yes  No

Next recall date: \_\_\_\_\_ / \_\_\_\_\_ (month/year)

More appointments needed for treatment?  Yes  No

If yes: Approximate number of appointments needed: \_\_\_\_\_ Next appointment: Date: \_\_\_\_\_ Time: \_\_\_\_\_

### Additional Information for Parents, Head Start Staff, and Medical Providers

### Oral Health Provider's Contact Information and Signature

Provider name (please print) \_\_\_\_\_ Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

Practice name \_\_\_\_\_ Address \_\_\_\_\_

Provider signature \_\_\_\_\_ Date of service \_\_\_\_\_