



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 _____