Dental Health Form

Patient Information (To be completed by Head Start staff)

Child's name	Date of Birth	FID#
Site Name	**Phone**	**Fax**

I. Oral Health Care Services Delivered During Visit (completed by Dental Professional)

Date of Exam _______ / _______ / _______ **AND/OR** **Date of Treatment** _______ / _______ / _______

Diagnostic/Preventive Services			Restorative/Emergency Care			In diagram below Indicate oral condition before treatment
Examination:	☐ Yes	☐ No	Fillings	☐Yes	☐No	Missing Tooth / Decayed / Filled Cavities
X-rays:	☐ Yes	☐ No	Crowns	☐Yes	☐No	
Cleaning:	☐ Yes	☐ No	Extractions	☐Yes	☐No	
Fluoride varnish:	☐ Yes	☐ No	Emergency Care	☐Yes	☐No	
Dental sealants:	☐ Yes	☐ No	Other (specify:)	☐Yes	☐No	
Counseling/Anticipatory Guidance provided:	☐ Yes	☐ No				
Oral Hygiene Instructions provided:	☐ Yes	☐ No	**Comments:**			
All treatment completed: (*If "No", complete section II*)	☐Yes	☐No				

UPPER: O E F G, C, H, B, LINGUAL, I, A, J, 3, 14, RIGHT, LEFT
LOWER: 30, 19, T, K, S, LINGUAL, L, R, M, Q, P, O, N

II. Future Dental Treatment Needed (completed by Dental Professional)

Unable to proceed with treatment ☐ No ☐ Yes – **Specify:**

Child referred to Pedodontist/Specialist: ☐ No ☐ Yes – **Specify:**

Check the procedures needed:

☐ Fillings ☐ Crowns ☐ Extractions ☐ Emergency care

☐ Other – **Specify:**

More appointments needed for treatment: ☐ **Yes** ☐ **No**
If Yes: Approximate number of appointments needed: __________
Next appointment date: _________ / _________ / ________ Time: _____ : _____

If no treatment needed or treatment complete, Date of Next Recall: _________ / _________ / ________

III. Oral Health Provider's Contact Information and Signature/Official Stamped Signature

Print Name: ____ Phone: ________________________

Signature/Official Stamp: __________________________________ Fax: ___________________________

******** **Early Head Start / Head Start Staff Only** ******** **Date Received:** _____/_____/________