THE NATIONAL CENTER ON Health

College of Education
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Head Start Oral Health Form—Children

Patient Information

Child's name **Child's date of birth**

This practice is the child's dental home: Yes No Date of Service:_____

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: _____

Permission for Release of Information / Permiso de Proveer Información

I give permission for the healthcare provider to release the requested information to DACHS.
Yo doy permiso a mi doctor para dar la siguiente información a DACHS.

Parent or Guardian signature/Firma: _____ Date/Fecha:_____

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* Phone number Fax number

Practice name Address

Provider signature

ENTERED INTO CHILDPLUS
Date:
By:

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