National Center on
Health, Behavioral Health, and Safety

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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 filling , 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
Silver diamine fluoride: ○ 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
Silver diamine fluoride: ☐ 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

ENTERED INTO CHILDPLUS
Date: ____________________
By:

This resource is supported by the Administration for Children and Families (ACF) of the United States (U.S.) Department of Health and Human Services (HHS) as part of a financial assistance award totaling $7,600,000 with 100% funded by ACF. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, ACF/HHS or the U.S. Government.