



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 Dental Exam

ENTERED INTO CHILDPPLUS
Date:
By: