

Head Start Oral Health Form—Children

Patient Inform	ation								
hild's name		Date of	birth	Parent's/guardian's n	ame	Phone number			
Address					City		State	Zip	code
This practice is the	child's o	dental ho	me: Ye	s No					
Current Oral H	ealth S	tatus							
Does the child hav Does the child hav or extractions? Are there treatmer Oral Health Ca	e any te Yes nt needs	eeth that h No s? Yes,	nave previo urgent	ously bee Yes, not	en treated for decay, incl t urgent No treatme		vns,		
Diagnostic/Preve	entive S	Services	Counse	eling/An	ticipatory Guidance	Restorative/E	merge	ncy (Care
Examination:	Yes	No	Yes	No		Fillings:	Y	es	No
X-rays:	Yes	No				Crowns:	Y	es	No
Risk assessment:	Yes	No	Referra	al to Spe	ecialty Care	Extractions:	Y	es	No
Cleaning:	Yes	No	Yes	No		Emergency care	e: Y	es	No
Fluoride varnish:	Yes	No				Other:			
Dental sealants:	Yes	No	(Please	specify specialist) (Please specify)					
Future Oral Hea	alth Ca	re Servi	ces						
All treatment comp More appointment If ves: Approximat	ts neede				Next reca No Next appointme	III date: / ent: Date:		-	
Additional Info	ormatio	on for Pa	irents, He	ad Star	t Staff, and Medical I	roviders			
Oral Health Pro	• • •		4 1						

Provider name (<i>please print</i>)	Phone number Fax number		
Practice name	Address		
Provider signature	Date of service		

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