



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	Counseling/Anticipatory Guidance	Restorative/Emergency Care
Examination: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="radio"/> Yes <input type="checkbox"/> No	Fillings: <input type="checkbox"/> Yes <input type="checkbox"/> No
X-rays: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral to Specialty Care <input type="checkbox"/> Yes <input type="checkbox"/> No _____ (Please specify specialist)	Silver diamine fluoride: <input type="checkbox"/> Yes <input type="checkbox"/> No
Risk assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No		Crowns: <input type="radio"/> Yes <input type="radio"/> No
Cleaning: <input type="checkbox"/> Yes <input type="checkbox"/> No		Extractions: <input type="checkbox"/> Yes <input type="radio"/> No
Fluoride varnish: <input type="checkbox"/> Yes <input type="checkbox"/> No		Emergency care: <input type="checkbox"/> Yes <input type="radio"/> No
Silver diamine fluoride: <input type="radio"/> Yes <input type="radio"/> No		Other: _____ (Please specify)
Dental sealants: <input type="radio"/> Yes <input type="radio"/> No		

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	