



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: Yes No	Yes No	Fillings: Yes No
X-rays: Yes No	Referral to Specialty Care	Silver diamine fluoride: Yes No
Risk assessment: Yes No		Crowns: Yes No
Cleaning: Yes No	Yes No	Extractions: Yes No
Fluoride varnish: Yes No	_____	Emergency care: Yes No
Silver diamine fluoride: Yes No	(Please specify specialist)	Other: _____
Dental sealants: Yes No		(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	