

## **Head Start Oral Health Form—Children**

Patient Inform	ation										
 Child's name	hild's name Date of birth				Parent's/guardian's name				Phone number		
Address This practice is the child's dental home: Ye				City Yes No				State	Zip	code	
Current Oral H	ealth S	tatus									
Does the child hav Does the child hav or extractions? Are there treatmer	e any te Yes at needs	eeth that h No s? Yes,	ave previou	sly beer 'es, not	n treated for urgent			owns,			
Diagnostic/Preve					icipatory (	- Luidanca	Restorative	/Emora	onev.	Caro	
Examination: X-rays: Risk assessment: Cleaning: Fluoride varnish: Dental sealants:	Yes Yes Yes Yes Yes Yes	No No No No No No No	Yes <b>Referral</b>	No to Spec	cialty Care		Fillings: Crowns: Extractions: Emergency co	are:	Yes Yes Yes Yes	No No No No	
Future Oral Hea	alth Ca	re Servic	es								
All treatment comp More appointment If yes: Approximat Additional Info	ts neede e numb	ed for treater of appo	ointments ne	eded: .		appointmen				·	
Oral Health Pro			t Informati	on and				numbor			
Provider name (please print)  Practice name						Phone number Fax number  Address					
Provider signature					— ——— Date of						

This document was prepared under grant #90HC0005 for the U.S. Department of Health and Human Services, Administration for Children and Families, Office of Head Start, by the National Center on Early Childhood Health and Wellness. This publication is in the public domain, and no copyright can be claimed by persons or organizations.