National Center on
Health, Behavioral Health, and Safety

# 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 fillings, 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
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 service

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