

Head Start Oral Health Form—Children

Patient Inform	ation										
Child's name	Child's name			birth	Parent's/guar	rent's/guardian's name			Phone number		
Address This practice is the child's dental hom			City ne: Yes No					State Z		ip code	
Current Oral H	ealth S	tatus									
Does the child hav Does the child hav or extractions? Are there treatmer	e any te Yes It needs	eeth that h No s? Yes,	ave previc urgent	Yes, not	n treated for de urgent No	No (dec cay, includ	ding fillings, cro	wns,			
Oral Health Ca											
Diagnostic/Preverse Examination: X-rays: Risk assessment: Cleaning: Fluoride varnish: Dental sealants:	Yes Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No No No	Yes Referra	No	cialty Care	dance	Restorative/E Fillings: Crowns: Extractions: Emergency can Other: (Please	Y Y Y re: Y	es es es es	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 trea er of appo	ointments	needed: ₋	lo Next ap	pointmen				·	
Oral Health Pro	ovider'	s Contac	t Informa	ntion and	d Signature						
Provider name (please print)					Phone nur	Fax n	Fax number				
Practice name					Address						
Provider signature					— Date of se	rvice					

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