

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 Referral	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						

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