THE NATIONAL CENTER ON Health

SCPS Head Start/Early Childhood Services
7409 Brock Road., Spotsylvania, VA 22553
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Head Start Oral Health Form

Patient Information — THIS SECTION TO BE FILLED OUT BY HEAD START STAFF

Child's name:_____ Child's date of birth: __ __ / __ __ / __ __ Child's gender: __M __ F

This practice is the child's dental home: ☐ Yes ☐ No

Child's race/ethnicity: Please check only one:

☐ White, not Hispanic origin ☐ Black, not Hispanic origin ☐ Asian or Pacific Islander
☐ American Indian or Alaska Native ☐ Hispanic ☐ Other/Multiracial

ALL SECTIONS BELOW TO BE FILLED OUT BY DENTIST

Current Oral Health Status

Date of service: __ __ / __ __ / __ __

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 (Presence of pain, infection, swelling. Care needed within 24 hours.)
☐ Yes, not urgent (Caries without above symptoms. Care needed within several weeks.)
☐ No treatment needs (None of the above signs/symptoms.)

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
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 the Attention of Pregnant Women, Parents, Head Start Staff, and Medical Providers

_____

_____

Oral Health Provider's Contact Information and Signature

_____ _____ _____
Print provider name Phone number Fax number

_____ _____
Practice name Address

_____ _____
Provider signature Date

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