



Head Start Program Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Phone \_\_\_\_\_  
 E-mail \_\_\_\_\_

**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 \_\_\_\_\_