Oral Health Form

Patient Information

_____ _____
Child's Name Child's date of birth

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

Does the child have gum disease? _____Yes _____ No

Are there treatment needs? _____Yes, urgent _____ Yes, and 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

Crowns: ___Yes ___No

Extractions: ___Yes ___No

Emergency care: ___Yes___ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ___Yes ____No

More appointments needed for treatment? ____Yes ____ No

If yes: Approximate number of appointments needed: _____

Next recall date: _____/_____ (month/year)

Specify treatment 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 Completed Date of Exam

OFFICE USE ONLY: Date Acquired: _____ Staff Initials: ____