THE NATIONAL CENTER ON Health

Delaware Opportunities, Inc.
35430 State highway 10
Hamden, NY 13782
Phone: 607-746-1640 Fax: 607-746-1648
Center:_____

Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

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

Are there treatment needs? Yes, urgent Yes, 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 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 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 of service _____

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DELAWARE OPPORTUNITIES INC. HEAD START
DENTAL HEALTH HISTORY

To be completed by parent prior to dental appointment

Child's Name_____ **DOB**_____

1. Is your child now receiving:

Topical fluoride application?	Yes_____	No_____
Fluoridated water?	Yes_____	No_____
Fluoride tablet?	Yes_____	No_____
At home?	Yes_____	No_____
At Head Start?	Yes_____	No_____

2. Is your child taking vitamins with fluoride? Yes_____ No_____

3. Does your child have trouble with

his/her teeth?	Yes_____	No_____
Pain?	Yes_____	No_____
Gums?	Yes_____	No_____
Mouth?	Yes_____	No_____

4. Has your child had any of the following?

Allergies	yes	no	Asthma	yes	no
Bleeding	yes	no	Diabetes	yes	no
Epilepsy/seizures	yes	no	Other	yes	no
Heart/Valvular Disease	yes	no			
Liver Disease	yes	no			
Sickle Cell Disease	yes	no			

Explain any yes answers_____

_____

Is your child taking any medication?_____

_____

If yes please explain_____

_____

Name of Healthcare Provider_____

Phone Number_____

Parents signature_____ **Date**_____