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

Head Start Center_____

DENTAL HEALTH FORM

Child's Name:_____ **DOB:**_____

Address:_____ **Phone:**_____

Patient Oral History

Flossing Frequency: ☐Daily ☐Weekly ☐Occasionally ☐Never

Gum Condition: ☐ Normal ☐Swollen ☐ Bleeds Easily ☐Infected

Number of times per day child brushes teeth:_____

Services provided today

_____ Exam

_____ Prophylaxis

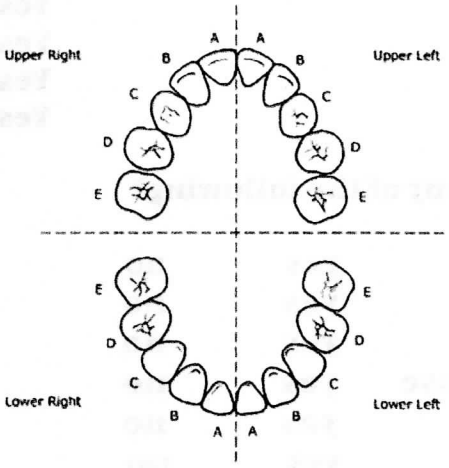
_____ Fluoride Treatment

_____Sealants

_____X-rays

_____ Treatment: (Specify)

Key: Decay=• Filled= 0 Missing= X



Further Dental Needs

☐ X-Rays

☐ Filling

☐ Sealants

☐ Crown

☐ Extraction

☐ Other: (specify)

Status of Dental Care

Was the exam completed by a Dentist? YES NO

Is all necessary service complete at this time? YES NO If No, Explain_____

Is this child in the process of ongoing treatment? YES NO If Yes, Explain_____

Is this child being referred? YES NO If Yes, Explain_____

To Whom:_____

Date of Return Appointments? _____ **Is this upcoming appointment for: RESTORATIVE or PREVENTIVE**

Signature of Dentist_____ **Date**_____

Print or stamp Dentist name below: Please note: Dentist signature is required by Head Start Regulations: Services provided by a RDH must be co-signed by Dentist

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 <u>yes</u> answers_____

_____

Is your child taking any medication?_____

_____

If yes please explain_____

_____

Name of Healthcare Provider_____

Phone Number_____

Parents signature_____ **Date**_____