Head Start Oral Health Form—Children

**Patient Information**

<table>
<thead>
<tr>
<th>Child's name</th>
<th>Date of birth</th>
<th>Parent's/guardian's name</th>
<th>Phone number</th>
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<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip code</th>
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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**

- Referral to Specialty Care

**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**

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<tr>
<th>Provider name (please print)</th>
<th>Phone number</th>
<th>Fax number</th>
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<th>Practice name</th>
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Provider signature

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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?
   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?
   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_________________________