



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 _____

**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?**

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** _____