EARLY HEAD START/HEAD START DENTAL EXAM FORM

2002 Sudderth Dr. Ruidoso, NM 88345
Phone: (575) 651-1802 Fax: (575) 855-625-5183

Head Start requires a COMPLETE DENTAL EXAM. Documentation of ALL screenings is necessary in order to provide prompt assistance to families to best meet the health and developmental needs of the child.

***Please complete all boxes, sign and date, and return this form to the parent or fax to the number above.**

PARENT/GUARDIAN- PLEASE COMPLETE THIS PORTION OF THE FORM	
CHILD'S NAME	**DATE OF BIRTH**
IS THERE ANYTHING YOU WOULD LIKE YOUR PROVIDER TO KNOW ABOUT YOUR CHILD PRIOR TO THEIR APPOINTMENT? (EX: DENTAL ANXIETY, DISABILITIES, HEALTH CONCERNS, ETC.)	

HEALTH CARE PROVIDER INFORMATION	
PHYSICIAN NAME	SIGNATURE
CLINIC/TYPE OF PRACTICE	DATE OF EXAM
ADDRESS	
TELEPHONE	IS THIS PRACTICE 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 filing, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needed

ORAL HEALTH CARE SERVICES DELIVERED DURING VISIT

Diagnostic/Preventive Services

Examination:	☐ Yes	☐ No
X-Ray:	☐ Yes	☐ No
Risk assessment:	☐ Yes	☐ No
Cleaning:	☐ Yes	☐ No
Fluoride:	☐ Yes	☐ No
Dental sealant(s):	☐ Yes	☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____

(Please specify specialist and treatment being referred for)

Restorative/Emergency Care

Fillings:	☐ Yes	☐ No
Crowns:	☐ Yes	☐ No
Extractions:	☐ Yes	☐ No
Emergency:	☐ Yes	☐ No
Other (Please *Specify):*	☐ Yes	☐ No

FUTURE ORAL HEALTH CARE SERVICES

All treatment completed: ☐ Yes ☐ No

If NO, next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If YES: Approximate number of appointments needed to complete treatment.:

Next prophylaxis appointment: Date _____ Time _____

Additional Information for Parents, Early Head Start & Head Start Staff, and Medical Providers

For Program Use Only:	*Date Received:*	*Received By:*