Public Health
Seattle & King County

Program Name: RIFC
Phone Number: 206-767-6896
Fax Number: 206-767-4997

DENTAL EXAMINATION
Head Start/Early Head Start/ECEAP/Step Ahead

Exam Date:_____

Child's Last Name First Middle Birth Date Sex

1. Risk Classification for Dental Caries

____Low Risk
- ☐ No Caries or Restorations

____Moderate Risk
- ☐ One Carious lesion
- ☐ Deep Pits and fissures
- ☐ White spots or hypocalcification
- ☐ Dental restoration

____High Risk
- ☐ **# Caries_____**
- ☐ Multiple Missing Teeth
- ☐ Extensive dental restorations

2. Preventative Treatment Received

- ☐ Brush/Floss
- ☐ Cleaning
- ☐ Sealants
- ☐ Fluoride Treatment
- ☐ Glass Ionomer (IRTs)
- ☐ Education

4. Treatment Needed at Next Visit

___ No Treatment Needed, Recall in Six Months

___ Dental Restorations or Extractions

___ Approximate number of visits needed to complete treatment

Next Appointment Date**:** _____

___ **Needs Referral to a Pediatric Dentist**

Referred to: _____
Name

_____
Phone Number Date

Appointment Made: Yes_____ No_____

___ **Needs Treatment Under General Anesthesia**

_____
Appointment Date

3. All Restorative Treatment Completed

Date Completed: _____

Next Routine Exam: _____

Please complete the following information so that we may work with you to assure this child receives needed treatment:

_____ **DENTIST SIGNATURE**

_____ **CLINIC NAME**

_____ **CLINIC PHONE**

Please return to parent or Fax to: 206 767-4997