Renaissance Head Start
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NATIONAL CENTER ON Early Childhood Health and Wellness

Head Start Oral Health Form

Child's Name _____ Date of Birth _____

Parent/Guardian's Name _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

This practice is the child's dental home? Yes No

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

Diagnostic/Preventative 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)

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)

Provider Name (print) _____ Phone number _____ Fax Number _____

Practice name _____ Address _____

Provider signature _____ Date of Service _____

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