



DENTAL HEALTH FORM



Child's Name: First _____ Last _____ Sex ____ Date of Birth: ____ / ____ / ____
 Head Start Site: _____ Phone: () _____ Fax: () _____

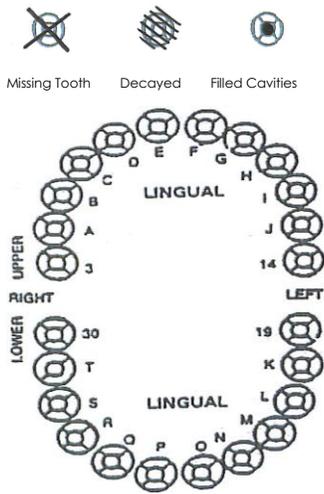
- TO BE COMPLETED BY DENTAL PROFESSIONAL -

Procedures/Services Performed during visit: (Please check all that apply)

Date of Visit: _____

- Clinical Examination Prophylaxis /Cleaning Fluoride Treatment
- Oral Hygiene Instructions Treatment/restoration **(list below)** Fluoride Varnish
- Visual Exam only Other - Please Specify: _____

In diagram below Indicate oral condition before treatment



Please list below dental treatment /restoration performed:

Tooth # or Letter	Surfaces	Description of Service	Date Service Performed (if applicable)		
			MO	DAY	YR

- NO FURTHER TREATMENT RECOMMENDED AT THIS TIME.**
- ADDITIONAL DENTAL NEEDS ARE REQUIRED (Please check one or more)**
- Prophylaxis/cleaning
 - Fluoride Treatment
 - Dental Treatment/Restoration: _____
 - Other - Please Specify: _____
- NEXT APPOINTMENT IS SCHEDULED FOR:** _____
- UNABLE TO PROCEED WITH TREATMENT, CHILD NEEDS TO BE REFERRED TO A PEDIODONTIST.**

COMMENTS:

I certify that I have completed the service(s) listed above.

Print Name of Dentist: _____ Signature/ Official Stamped Signature: _____
 Date _____
 Address: _____
 Phone: _____ Fax Number: _____

