CHILD DENTAL RECORD:

COMPLETE AT INTERVIEW

CHILD'S NAME: ____________________ SEX: ______ BIRTHDATE: ____________

HEAD START CENTER: ____________________ PHONE: ____________

ADDRESS: ____________________

1. IS THE CHILD NOW RECEIVING: If "Yes" include length of time receiving flouride
   - Topical Flouride Application? No ☐ Unknown ☐ Yes ☐ ______
   - Flouridated Water? No ☐ Unknown ☐ Yes ☐ ______
   - Flouride Supplement Diet? No ☐ Unknown ☐ Yes ☐ ______
   - (tablets ☐, liquid ☐)

2. DOES THE CHILD HAVE ANY OTHER TROUBLE WITH TEETH, GUMS OR MOUTH THAN THE PARENTS KNOWS ABOUT?

PART I. TO BE COMPLETED BY HEAD STAFF

3. CHILD (☐ HAS, ☐ HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name ____________ Date last visit ____________
4. CHILD (☐ IS, ☐ IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name ____________
5. CHILD (☐ IS, ☐ IS NOT) RECEIVING MEDICATION.
   Type ____________
6. CHILD IS REPORTING TO HAVE (Give details or attach Health History, Form 2A)

	YES	NO		YES	NO
Allergies	____	____	Liver Dis	____	____
Asthma	____	____	Rheumatic Fever	____	____
Bleeding	____	____	Sickle Cell Dis	____	____
Diabetes	____	____	Other (List Below)	____	____
Epilepsy	____	____			
Heart / Vasc Dis	____	____			

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT / Medicaid
   - ☐ CASE ID# ____________
   - ☐ CHILD ID# ____________
   - ☐ Head Start
   - ☐ In-kind Provider
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party)
8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT:
   - missing ⊗
   - decayed ●
   - or filled ◉

   Indicate restorations you perform in item 10

   UPPER — D E F G H C LINGUAL B I A J 8 14
   RIGHT LEFT
   LOWER — 30 19 T K S L R LINGUAL M Q P O N

10. EXAMINATION AND TREATMENT RECORD (List recommended services in order).

Teeth # or Letter	Surfaces	Description or Work	Treatment Approved	Date Services Performed M	D	Y	A.D.A. Procedure Number	Actual Charges (Fee)
		▪ *Examination*					*00110*	
		▪ *Prophylaxis*					*01120*	
		▪ *Topical Application*					*01230*	
		of Fluoride						

11. DENTAL NEEDS (Check one or more and return 3 copies to Head Start after first visit).
    - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
    - ☐ B. CLEANING
    - ☐ C. FLUORIDE
    - ☐ D. SEALANTS
    - ☐ E. OTHER
    - ☐ F. NO PROBLEMS

    Approximate Number of Visits ____________ Approximate Cost ____________

12. CHILD ORAL HEALTH SUMARY (Complete and return 2 copies to Head Start after final visit).
    All planned treatment (☐ is, ☐ is not) complete. If not, explain here, as well as items checked.

    ____

    ____

    - ☐ A. Routine recall visits
    - ☐ C. Dietary problem(s)
    - ☐ E. Harmful oral habits
    - ☐ B. Special home emphasis, oral hyg
    - ☐ D. Developmental problem(s)
    - ☐ F. Needs fluoride supplement

I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

Dentist's Signature ____________ Name ____________ Date ____________

Address ____________ Phone ____________