Prince William County Head Start
P.O. Box 389
Manassas, Virginia 20108
703-791-8708 Office
703-791-8913 Fax

THE NATIONAL CENTER ON Health

Head Start Oral Health Form

Patient Information

_____ _____
Child's Name Child's Date of Birth

Current Oral Health Status

Does the child have any teeth with untreated decay? **O** Yes **O** No
Are there any treatment needs? **O** Yes, Urgent **O** Yes, not urgent **O** No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventative Services
Examination **O** Yes **O** No
X-Rays **O** Yes **O** No
Cleaning **O** Yes **O** No
Fluoride Varnish **O** Yes **O** No

Counseling/Anticipatory Guidance
O Yes **O** No

Referral to Specialty Care
O Yes **O** No

_____
(please specify specialist)

Restorative/Emergency Care
Fillings **O** Yes **O** No
Crowns **O** Yes **O** No
Extractions **O** Yes **O** No
Emergency care: **O** Yes **O** No

Other _____
(please specify)

Future Oral Health Care Services

All treatment completed **O** Yes **O** No
More appointments needed for treatment **O** Yes **O** No
If yes: approximate number of appointments needed _____ (Next appointment date_____)

Additional Information/Notes

Oral Health Provider's Contact Information and Signature *(form in not considered valid without proper contact information)*

This practice is the child's dental home: **O** Yes **O** No

_____ _____ _____
Provider Name *(please print)* Phone Number Fax Number

_____ _____
Practice Name Address

_____ _____
Provider Signature/Authorized Signature Date of Exam