CHILD HEALTH RECORD: FORM 5, DENTAL HEALTH

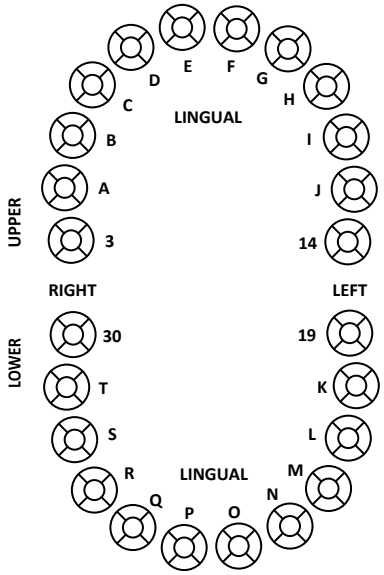
CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

HEAD START CENTER:_____ PHONE:_____

1. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAT THE PARENT KNOWS ABOUT?

2. PAYMENT/INSURANCE INFORMATION:

3. ORAL CONDITIONS BEFORE TREATMENT:
missing (⊗), decayed (◎), or filled (◉); indicate restorations you perform in item 4.



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

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Services Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)	

DATE DENTAL SERVICES PROVIDED: _____

EXAM _____ FLUORIDE _____ PROPHY _____ X-RAYS _____ SEALANTS _____

TREATMENT (restoration, pulp therapy, extraction, etc) _____ *(See section below if treatment is not complete)*

OTHER _____ **DATE OF NEXT ROUTINE EXAM:** _____

DENTAL SERVICES NEEDED:

EXAM _____ FLUORIDE _____ PROPHY _____ X-RAYS _____ SEALANTS _____ OTHER _____

TREATMENT (restoration, pulp therapy, extraction, etc) _____ REFERRAL _____

Approximate number of visits to complete treatment: _____

Dates of scheduled appointment(s):_____

SUMMARY OF DENTAL SERVICES:

_____ All planned treatment **is** complete

_____ All planned treatment **is NOT** complete

_____ Treatment was Referred

_____ No treatment needed at this time; routine recall visits

Provider Signature _____ **Date** _____

Modified for use by Region 7 Education Service Center Early/Head Start