



## Head Start Oral Health Form

### Patient Information

Pregnant woman's/child's name \_\_\_\_\_ Date of birth \_\_\_\_\_ Phone number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
This practice is the pregnant woman's/child's dental home: Yes No

### Current Oral Health Status

Does the pregnant woman or child have any teeth with untreated decay? Yes (decay) No (decay free)  
Does the pregnant woman or child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? Yes No  
Does the pregnant woman have gum disease? Yes No  
Are there treatment needs? Yes, urgent Yes, not urgent No treatment needs

### Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services	Counseling/Anticipatory Guidance	Restorative/Emergency Care
Examination: Yes No	Yes No	Fillings: Yes No
X-rays: Yes No		Crowns: Yes No
Risk assessment: Yes No	Referral to Specialty Care	Extractions: Yes No
Cleaning: Yes No	Yes No	Emergency care: Yes No
Fluoride varnish: Yes No	_____	Other: _____
Dental sealants: Yes No	(Please specify specialist)	(Please specify)

### Future Oral Health Care Services

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: \_\_\_\_\_

### Additional Information for Patient, Head Start Staff, and Medical Providers

### Oral Health Provider's Contact Information and Signature

Provider name (please print) \_\_\_\_\_ Phone number \_\_\_\_\_ Fax number \_\_\_\_\_  
Practice name \_\_\_\_\_ Address \_\_\_\_\_  
Provider signature \_\_\_\_\_ Date of service \_\_\_\_\_