NATIONAL CENTER ON
Early Childhood Health and Wellness

Renaissance Head Start
13110 14th Street Detroit, MI 48238
Ph: 313-867-0500
Fx: 313-867-5112

Head Start Oral Health Form

Child's Name ________________ Date of Birth ________________

Parent/Guardian's Name ________________ Phone Number ________________

Address ________________ City ________ State ________ Zip Code ________

This practice is the child's dental home? Yes No

Does the child have any teeth with untreated decay? Yes (decay) No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions?
Yes ____ No

Are there treatment needs? Yes, urgent Yes, not urgent No treatment needs

---

Diagnostic/Preventative Services

Examination: Yes No

X-Rays: Yes No

Risk Assessment: Yes No

Cleaning: Yes No

Fluoride Varnish: Yes No

Dental Sealants: Yes No

Counseling/Anticipatory Guidance

Yes No

Referral to Specialty Care

Yes No

____
(Please specify specialist)

Restorative/Emergency Care

Fillings: Yes No

Crowns: Yes No

Extractions: Yes No

Emergency Care: Yes No

Other: __________________________
(Please specify)

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)

Provider Name (print) ________________ Phone number ________________ Fax Number ________________

Practice name ________________ Address ________________

Provider signature ________________ Date of Service ________________

Rev 07/01/2018