

CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH



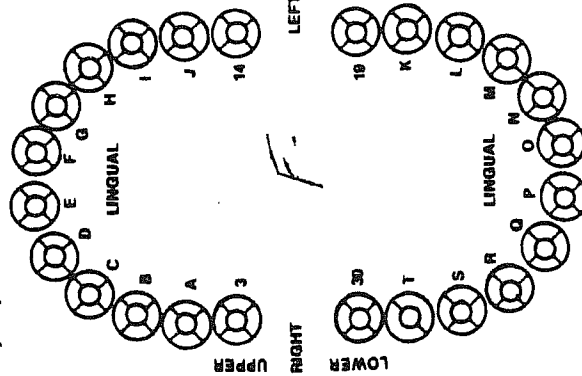
CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____
 HEAD START CENTER: _____ PHONE: _____
 ADDRESS: _____

1. IS THE CHILD NOW RECEIVING:
 If "yes," include length of time receiving fluoride
 Topical Fluoride Application? No ___ Unknown ___ Yes ___
 Fluoridated water? No ___ Unknown ___ Yes ___
 Fluoride Supplement diet? (tablets ___ liquid ___)
 No ___ Unknown ___ Yes ___

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

3. CHILD (___) HAS (___) PREVIOUSLY SEEN A DENTIST.
 Dentist's name _____ Date last visit _____
 4. CHILD (___) IS (___) UNDER A PHYSICIAN'S CARE.
 Physician's name _____
 5. CHILD (___) IS (___) RECEIVING MEDICATION.
 Type _____
 6. CHILD IS REPORTED TO HAVE (Give details or attach Health History, Form 2A). YES NO
 Allergies _____ Liver Dis. _____
 Asthma _____ Rheumatic Fever _____
 Bleeding _____ Sickle Cell Dis. _____
 Diabetes _____ Other (List Below) _____
 Epilepsy _____
 Heart/Vascular Dis. _____

7. SOURCE OF REIMBURSEMENT OR SERVICES
 EPSDT/Medicaid
 Federal, State, or local Agency
 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

9. ORAL CONDITIONS BEFORE TREATMENT: missing () or filled decayed () or filled (●); indicate restorations you perform in Item 10.


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

| Tooth # or Letter | Surfaces | Description of Work | Treatment Approved | Date Service Performed | | A.D.A. Procedure Number | Actual Charges (Fee) |
|-------------------|----------|---------------------|--------------------|------------------------|---------|-------------------------|----------------------|
| | | | | MO. | DAY YR. | | |
| | | EXAM | | | | | |
| | | PROPHY | | | | | |
| | | FLUORIDE | | | | | |
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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. OTHER
 E. NO PROBLEMS
 Approximate number of visits _____ Approximate cost _____

12. CHILD ORAL HEALTH SUMMARY (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.

 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.
 Signature _____ Date _____

(COMPLETE AT INTERVIEW) BY HEAD START STAFF PART I. TO BE COMPLETED BY DENTAL CARE PROVIDER PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER