Head Start Oral Health Exam Form

Child's Name___________________________________ DOB________________

Date of Exam: ______________

Name of Provider [PRINT OR STAMP]

____
Name

____
Address

____
Phone

Services Provided Today:

_____ Exam

_____ Cleaning

_____ Topical Fluoride

_____ X – Rays

_____ Treatment: [PLEASE SPECIFY]

____

____

____

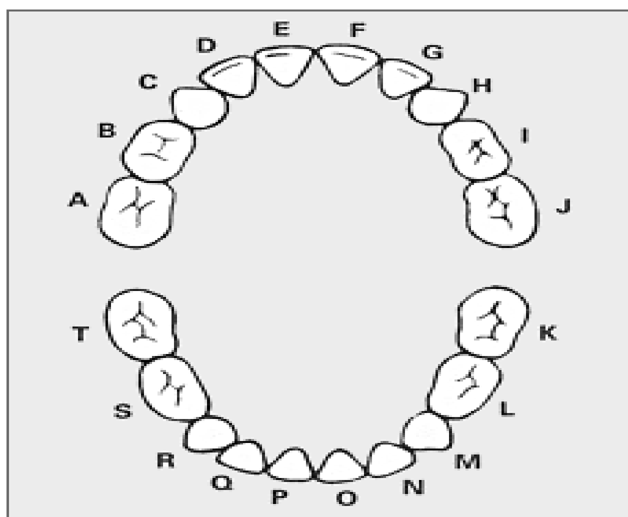
Dental Needs:

_____ Restoration

_____ Extraction

_____ Other {PLEASE SPECIFY]

____



X=DECAY

Status of Dental Care:

____ All necessary service is complete at this time
____ In process of ongoing treatment with this office ________ next appointment date
____ Child was uncooperative, recall in 6 months ________ next appointment date
____ Referred for dental exam and/or treatment to: ________________________________

Comments:____

____ ____________________
DENTIST SIGNATURE **DATE**

PLEASE RETURN FORM TO:

Greater Opportunities
44 West Main Street
Norwich, NY 13815
PHONE: [607] 334-7114: FAX: [607] 336-6958 Attn: Health Office