West River Head Start

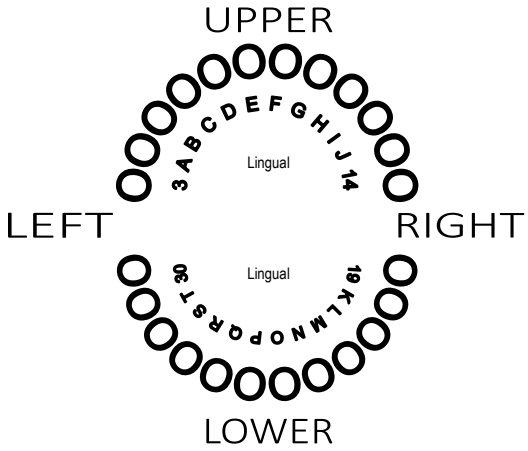
DENTAL EXAM / ORAL HEALTH FORM

Patient Information

Child's Name:	Child's DOB:	Date Exam / Screening Completed:

Current Oral Health Status

ORAL CONDITION	
Missing	
Decayed	
Filled	



Number of times per day child brushes teeth: _____

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

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

Oral Health Care Services Delivered During Visit

Diagnostic / Preventive Services

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)

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 parent, head start staff, and medical providers:

Oral Health Provider's Contact Information and Signature

Provider Name (printed)		Phone Number	Fax Number
Provider Signature	Date	Address	

Please return form to:

	West River Head Start 1004 7th Street SW Mandan, ND 58554 Tel (701) 663-9507 Fax (701) 663-9643	West River Head Start PO Box 197 Carson, ND 58529 Tel (701) 622-3505 Fax (701) 622-3236	West River Head Start PO Box 197 New Salem, ND 58563 Tel (701) 843-8061 Fax (701) 843-8061

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