CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____

HEAD START CENTER: _____ PHONE: _____

ADDRESS: _____

PART I. TO BE COMPLETED BY HEAD START STAFF (COMPLETE AT INTERVIEW)

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, ____HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name_____ Date last visit_____

4. CHILD (____IS, ____IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name_____

5. CHILD (____IS, ____IS NOT) RECEIVING MEDICATION.
   Type_____

6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___	_____		
Heart/Vascular Dis.	___	___	_____		

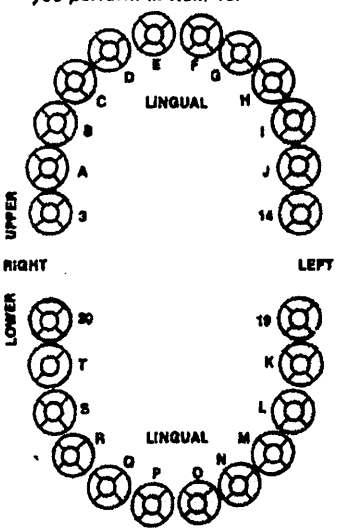
HEAD START

ATTENTION: HEALTH CARE PROVIDERS

Due to Federal guidelines that our program **must** meet, it is absolutely essential that this form be completed and signed. Please complete **section 9-12 and sign and date.**

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), 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 MO. DAY YR.	A.D.A. Procedure Number	Actual Charges (Fee)

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.

_____

_____

☐ a. Routine recall visits ☐ c. Dietary problem(s) ☐ e. Harmful oral habits
☐ b. Special home emphasis, oral hygiene ☐ d. Developmental problem(s) ☐ f. Needs fluoride supplement

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_____

INTERVIEWER: GO TO FORM 6