



## Head Start Oral Health Form

### Patient Information

Pregnant woman's/child's name \_\_\_\_\_

Pregnant woman's/child's date of birth \_\_\_\_\_

This practice is the pregnant woman's/child's dental home: Yes No

### Current Oral Health Status

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

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

Does the pregnant woman have gum disease? Yes No

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

### Oral Health Care Services Delivered During Visit

#### Diagnostic/Preventive 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)

### 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 Pregnant Women, Parents, Head Start Staff, and Medical Providers

### Oral Health Provider's Contact Information and Signature

Provider name (please print) \_\_\_\_\_

Phone number \_\_\_\_\_

Fax number \_\_\_\_\_

Practice name \_\_\_\_\_

Address \_\_\_\_\_

Provider signature \_\_\_\_\_

**Date of Exam** \_\_\_\_\_