TLINGIT & HAIDA HEAD START

Central Council Tlingit and Haida Indian Tribes of Alaska

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HEAD START CHILD DENTAL/ ORAL HEALTH EXAM

(Head Start requires complete annual dental/oral health exam documentation as necessary in order to provide prompt assistance to families to best meet the oral health care needs of the child. Please complete all boxes, sign, date, and provide a copy to parent/guardian and **FAX a copy to Tlingit & Haida Head Start @ 1.877.389).**

Patient /Child's name: _____ Date of birth: _____ Exam Date: _____

Parent's/guardian name: _____ Telephone number: _____

Mailing address:_____ City:_____ State:_____ Zip code:_____
This practice is the child's dental home: ____**Yes** _____**No**

Current Oral Health Status:
Does the child have any teeth with untreated decay? ____Yes (decay) _____No (decay free)
Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions?
_____Yes ____No
Are there treatments needs? ____Yes, urgent ___Yes, not urgent _____No treatment needs

Oral Health Care Services Delivered During Visit:

Diagnostic/Preventive Services:		**Counseling/Anticipatory Guidance:**	**Restorative/Emergency Care:**	
		___Yes ___No		
Exam:	___Yes ___No		Fillings:	___Yes ___No
Cleaning:	___Yes ___No	**Referral to Specialty Care:**	Crowns:	___Yes ___No
Fluoride Varnish:	___Yes ___No	____Yes ___No	Extractions:	___Yes ___No
Dental sealants:	___Yes ___No		Emergency	
Risk Assessment	___Yes ___No	_____	Care:	___Yes ___No
X-rays:	___Yes ___No	*(Specify Specialist)*	**Other:** _____	
			(Specify)	

Future Oral Health Care Services:

All treatment completed: ___Yes ___No Next treatment plan visit date: _____/_____(month/year)
More appointments needed for treatment? ___Yes ___No
If yes, approximately number of appointments needed: _____Next appointment scheduled: ____Yes ___No
Date: _____ Time:_____

Oral Health Provider's Contact Information and Signature:

Provider name (please print):_____Telephone:_____

Practice/clinic name:_____ Address:_____

Provider's Signature:_____ Date:_____

Parent / Legal Guardian Signature Authorizing Release: _____ Date:_____

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