CHILD HEALTH RECORD:

(COMPLETE AT INTERVIEW)

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

HEAD START CENTER: _____ PHONE: _____

ADDRESS: _____

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? No _____ Unknown _____ Yes _____
   (tablets _____, liquid _____)

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

PART 1. TO BE COMPLETED BY HEAD START STAFF

3. CHILD (____ HAS, ____ HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name _____

4. CHILD (____ IS, ____ IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name _____

5. CHILD (____ HAS, ____ HAS 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.	____	____	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider _____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party) _____

8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

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 Latter	Surface	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 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
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietry problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ 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 _____