HEAD START CENTER_____

HEAD START ORAL HEALTH RECORD

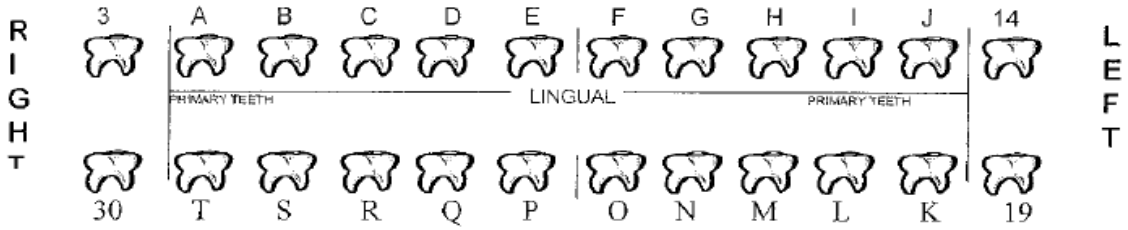
Child's Name_____ **Parent's Name**_____

Address_____ **Telephone #**_____

Date of Birth_____ **Dental Insurance** _____

THIS SECTION IS TO BE COMPLETED BY A DENTIST

UPPER



LOWER

DIAGNOSTIC CODES

SOLID AREA INDICATES FILLING PRESENT

ZEBRA STRIPES INDICATES DECAY

VERTICAL LINE INDICATES TO BE EXTRACTED

"X" INDICATES MISSING TOOTH

The above named child received:

☐ Oral Health Assessment ☐ Dental Prophylaxis (cleaning) ☐ Filling(s)
☐ Topical Fluoride Application ☐ Extraction(s) ☐ Treatment Complete

The following assessment has been made of his/her oral health:

☐ Tooth Decay ☐ Occlusion ☐ Needs a referral (specify) _____
☐ Missing Tooth/Teeth ☐ Extra Oral ☐ Uncooperative
☐ Needs remedial dental services (follow-up care)☐ Appointment date_____

I HEREBY CERTIFY THAT THE ABOVE SERVICES HAVE BEEN RENDERED

_____ _____ _____ _____
DENTIST'S Name **ADDRESS** **STATE** **CITY & ZIP CODE**

_____ _____ _____
DENTIST'S SIGNATURE **OFFICE PHONE NUMBER** Date