# CHILD HEALTH RECORD: FORM 5, DENTAL HEALTH

(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?

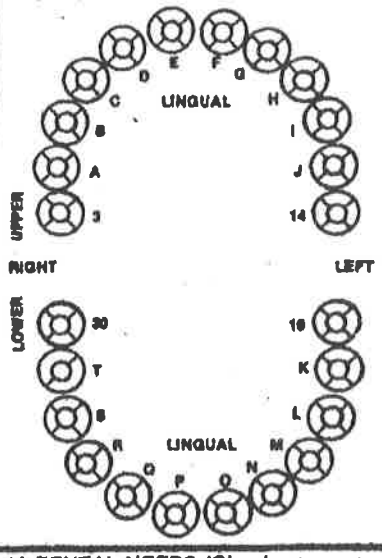
PART I. TO BE COMPLETED BY HEAD START STAFF

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. | ___ | ___ | _____ | | |

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

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) |
|---|---|---|---|---|---|---|
| | | | | | | |

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

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
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary 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_____

INTERVIEWER: GO TO FORM 6