CHILD HEALTH RECORD: FORM 5, DENTAL HEALTH

(COMPLETE AT INTERVIEW)

CHILD'S NAME:______________________ SEX:________ BIRTHDATE:__________

HEAD START CENTER:______________________ PHONE:__________

ADDRESS:______________________

PART I. TO BE COMPLETED BY HEAD START STAFF

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?

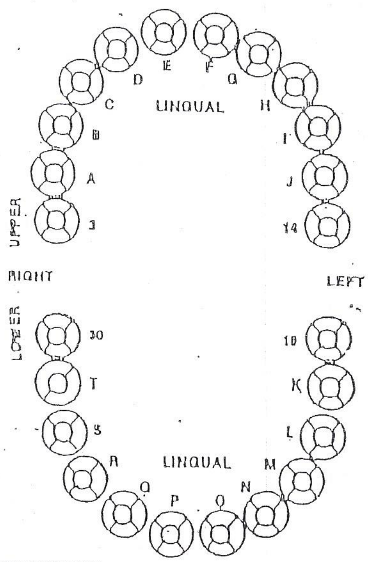
3. CHILD (___HAS, ___HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name_______________Date last visit__________
4. CHILD (___IS, ___IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name______________________
5. CHILD (___IS, ___IS NOT) RECEIVING MEDICATION.
   Type______________________
6. CHILD IS 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

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 Letter	Surfaces	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 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