NWCA HEAD START/EARLY HEAD START
PO Box 67 • Badger, MN 56714 • Office: (218) 528-3227 or (800) 568-5317 • Fax: (218) 528-3259

Head Start Oral Health Form – Children

Patient Information

_____ _____ _____ _____
Child's Name | Date of Birth | Parent's/Guardian's Name | Phone Number

_____ _____ _____ _____
Address | City | State | Zip Code

***Family Dental Provider Name**: _____ **Date of last visit:** _____

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 treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services
Examination: ☐ Yes ☐ No
X-Rays: ☐ Yes ☐ No
Risk Assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride Varnish: ☐ Yes ☐ No
Dental Sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance
☐ Yes ☐ No

Referral to Specialty Care
☐ Yes ☐ No
_____
(please specify specialist)

Restorative/Emergency Care
Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency: ☐ Yes ☐ No
Other: _____
(please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No Next Exam Date: _____
More Appointments needed for treatment? ☐ Yes ☐ No
If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Oral Health Provider's Contact Information and Signature

***If the estimated cost of services to be provided exceeds $250.00, contact NWCA HS/EHS for further authorization.**

Billed To: _____ Amount $_____ Date: _____

_____ _____ _____
Provider Name *(please print)* | Phone Number | Fax Number

_____ _____
Practice Name | Address

_____ _____
Provider Signature | Date