CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH

CHILD'S NAME: ___________________________ SEX: ___________________________
HEAD START CENTER: ______________________ PHONE: _________________________
ADDRESS: ________________________________

1. IS THE CHILD NOW RECEIVING:
- Topical Fluoride Application? Yes ___ No ___ Unknown ___
- Fluoridated water? Yes ___ No ___ Unknown ___
- Fluoride Supplement diet? Yes ___ No ___ Unknown ___

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).
   - AIDS
   - Rheumatic Fever
   - Sickle Cell Dis.
   - Other (List Below)

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 EXAMINATION AND TREATMENT RECORD (List recommended services in order).
   - Missing tooth(s)
   - Decayed tooth(s)
   - Filled tooth(s)
   - Indicate restorations you perform in Item 10.

10. EXAMINATION AND TREATMENT RECORD:

   Tooth # or Letter | Surfaces | Description of Work | Treatment Approved | Date Service Performed | 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