FREDERICKSBURG PRESCHOOL PROGRAMS
Serving Students in Fredericksburg Regional Head Start and Virginia Preschool Initiative
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Oral Health Form—Children

Patient Information

Child's name | Date of Birth | Parent's/Guardian's name | Phone number

Address | City | State | Zip code

This practice is the child's dental home: Yes No

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			Counseling/Anticipatory Guidance		Restorative/Emergency Care		
Examination:	Yes	No	Yes	No	Fillings:	Yes	No
X-rays:	Yes	No			Crowns:	Yes	No
Risk assessment:	Yes	No	**Referral to Specialty Care**		Extractions:	Yes	No
Cleaning:	Yes	No	Yes	No	Emergency care:	Yes	No
Fluoride varnish:	Yes	No	_____		Other: _____		
Dental sealants:	Yes	No	*(Please specify specialist)*		*(Please specify)*		

Future Oral Health Care Services

All treatment completed: Yes No Next recall date: _____ / _____ (month/year) More appointments needed for treatment? Yes No

If yes: Approximate number of appointments needed: ___ Next appointment: Date: ____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* | Phone number | Fax number

Practice name | Address

Provider signature | Date of service

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