DENTAL

DELAWARE COUNTY INTERMEDIATE UNIT
HEAD START
DENTAL FORM

Section I - To be Completed by Parent/Guardian		
Child's Name *(Last)* *(First)*	Gender ❑Male ❑ Female	Date of Birth
Parent/Guardian Name	Telephone Number	Center Location
I give my consent for my child's Dentist and Child Care Provider to discuss my child's health concerns.		
Parent/Guardian Signature	*Date*	

Section II – To be Completed by Dentist

Date of Exam: _____

Health history pertinent for routine child care including allergies, asthma, seizure disorders and special needs:
❑ None

Examination and Treatment Record
❑No Problems
❑Issue, please describe:
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❑ Prophylaxis/Cleaning	❑ Fluoride	❑ Other: _____
Treatment		
❑ Needs Treatment	Scheduled Date: _____	❑ Treatment Complete Date: _____

Child Oral Health Summary **Comments:**

❑ Special Home Emphasis, oral hygiene: _____
❑ Dietary Problems: _____
❑ Developmental Problems: _____
❑ Harmful Oral Habits: _____
❑ Other: _____

Please Print/Stamp

Dental Provider:

Address:

Phone Number:

Next Appointment Date:

_____

_____
Provider Signature ***Date***

Please attach any plans of care to this form

Revised 1/17/13