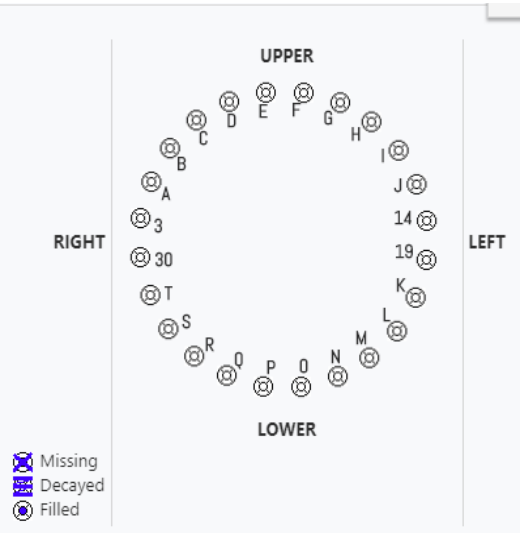
Region 14/15 Head Start / Early Head Start
Oral/Dental Exam

Date of exam: ____/____/____

Name: _____DOB_____

Early Head Start and Head Start Programs are required to obtain a statement from a dental healthcare professional determining whether a student is up-to-date on a schedule of age appropriate preventive oral health care. The Texas Health Steps Dental Periodicity Schedule is utilized to determine age appropriate.

Is this practice the child's dental home?
Yes____ No_____



<u>Oral/Dental Health Care Services completed during visit</u>:

Examination:			**Yes**	**No**		
Preventative Services Received?			**Yes**	**No**		
Cleaning:	Yes	No	Risk Assessment:		Yes	No
Fluoride varnish:	Yes	No	X-rays:		Yes	No
Dental sealants:	Yes	No				
Dental Treatment Needed?			**Yes**	**No**		
Dental Treatment Received?			**Yes**	**No**		

What treatment needed / received? Please put in the comment section below.

All treatment completed? Yes No

More appts needed for treatments?Yes No Please put tx needed in comments below.

- **Next appointment for treatments:** Date_____Time_____

Referred to: _____

Comments:_____

_____

_____

Next routine appointment date: _____ Time_____
(Every 3-6 months)

Provider Signature _____ **Date** _____

Print Provider Name _____

Address_____**Phone**_____

Head Start Use Only: Date received_____**Initial**_____

Form Updated 12/2019