HEAD START

DENTAL HISTORY, DIAGNOSIS, COST AND TREATMENT RECORD

Class ____________________

Center ____________________

Child's Name ______________________________ Sex _____ Birthdate ___/___/___ Phone ______________

Parent's Name ____________________________ Address ______________________________________

Child Medicaid No. ____________________

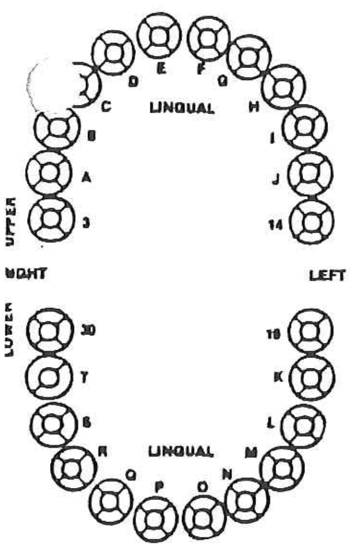
IS THE CHILD NOW RECEIVING:	YES	NO	If Yes, Include Length of Time
1. Topical Fluoride Application?			
2. Fluoride Supplement Diet? (tablets, liquid)			
3. Has Child Previously Seen a Dentist? Dentist 's Name ______________, date last visit______________			
4. Is Child under a Physician's Care?			Physician:______________
5. Is Child Receiving Medication?			Condition: ______________ Medicine:______________
6. Does Your Child Have Gum Disease?			
7. Cavities?			
8. Dental Pain (toothache)			

9. Child is Reported to Have : ___ Allergies, ___ Asthma, ___ Bleeding, ___ Diabetes, ___ Epilepsy ___ Heart/Vascular Dis., ___ Liver Dis., ___ Rheumatic Fever, ___ Sickle Cell Dis., ___ Other

10. Source of Reimbursement: ___ Private, ___ EPSDT/Medicaid, ___ Dental Clinic, ___ Headstart

EXAMINATION AND TREATMENT RECORD:

ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (⊘), or filled (●); indicate restorations you perform in item 12.*



Date	Tooth #	Surface(s)	Material	Description of Work (Separate line tooth)	Fee

All necessary treatment complete Yes ❏ No ❏ **TOTAL COST** ______

SOURCE OF REIMBURSEMENT OR SERVICES

❏ EPSDT/Medicaid
❏ Federal, State or Local Agency
____
❏ Headstart
❏ In-kind Provider ______________
❏ Parents/Guardians
❏ Other (3rd Party) ______________

PRIORITY GROUP

❏ A. Needs Attention Immediately
❏ B. Needs Attention Soon
❏ C. Needs Routine Care

Dentist ______________________________ Dentist's Signature ______________________________ Date ____________
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White - Center **Yellow** - Parent