White Copy: Central Office
Yellow Copy: Central Office
Pink Copy: Dentist

DENTAL HEALTH RECORD

COMPLETE AT INTERVIEW

CHILD'S NAME: _____ DOB _____

Community Action Program, Inc. of Western, Indiana
P.O. Box 188 • Covington, IN 47932
765-793-4881

TEACHER _____

AM_____ PM_____

1. IS THE CHILD NOW RECEIVING: *If "yes", include length of time receiving flouride*
   - Topical Flouride Application: No_____Unknown_____Yes_____
   - Flouridated water? No_____Unknown_____Yes_____
   - Flouride Supplement diet? No_____Unknown_____Yes_____
     (tablets_____, liquid_____)

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAT THE PARENT KNOWS ABOUT?

TO BE COMPLETED BY HEAD START STAFF

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).

	YES	NO		YES	NO
Allergies	____	____	Liver Disease	____	____
Asthma	____	____	Rheumatic Fever	____	____
Bleeding	____	____	Sickle Cell Disease	____	____
Diabetes	____	____	Other (List Below)	____	____
Epilepsy	____	____	_____		
Heart/Vascular Dis.	____	____	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ❑ Hoosier Healthwise
   - ❑ Head Start
   - ❑ Other Insurance _____

8. PRIORITY GROUP
   - ❑ A. Needs Attention Immediately
   - ❑ B. Needs Attention Soon
   - ❑ C. Needs Routine Care

TOOTH DIAGRAM

RIGHT PRIMARY TEETH — A B C D E — UPPER — F G H I J — PRIMARY TEETH LEFT
LINQUAL
T S R Q P — LOWER — O N M L K

PLACE AN "X" ON TEETH REQUIRING TREATMENT.

DENTAL SCREENING AND TREATMENT

SERVICES PROVIDED: (PLEASE RECORD EACH TREATMENT ON SEPARATE LINE)

MONTH	DAY	YEAR	TOOTH	SURFACE	MATERIAL	DESCRIPTION OF WORK	FEE
						TOTAL	

CHECK ONE:
Urgent _____
Routine _____
Low Priority _____

OTHER OBSERVATIONS:
_____
_____
_____

★ TREATMENT CODE — SURFACES: M - MESIAL, D - DISTAL, O - OCCLUSAL, L - LINGUAL, I - INCISAL, B - BUCCAL OR LABAL
MATERIALS: A - AMALGAM, S - SILICATE, P - ACRYLIC, C - STEEL CROWN, O - OTHER

TREATMENT

ADDITIONAL TREATMENT NEEDED: (DO NOT DATE UNTIL RENDERED)
SERVICES PROVIDED: (PLEASE RECORD EACH TREATMENT ON SEPARATE LINE)

MONTH	DAY	YEAR	TOOTH	SURFACE	MATERIAL	DESCRIPTION OF WORK	FEE
						TOTAL	

Estimated Cost of Treatment:
$_____

Agency Authorization
Initials: _____
Date: _____

CHILD ORAL HEALTH SUMMARY
All planned treatment (____is, ____is not) complete. If not, explain:
_____
_____

_____

I hereby certify that the services listed above have been performed:

Dentist's Signature/Address: _____

HS-7 2/16