

Geminus Head Start Oral Health Form

Patient Information (For age eligible Children or Pregnant Mother)

Name _____ Date of birth _____

Is the dental practice completing exam the dental home of patient?: 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		Emergency care: Yes No
Fluoride varnish: Yes No	_____	Other: _____
Dental sealants: Yes No	<i>(Please specify specialist)</i>	<i>(Please specify)</i>

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 <i>(please print)</i>	Phone number	Fax number
Practice name	Address	
Provider signature	Date of service	