RENAISSANCE HEAD START (313) 867-0500
13110 Fourteenth St., Detroit, MI 48238

CHILD'S DENTAL RECORD
DENTAL HISTORY and EXAMINATION FORM

(COMPLETE AT INTERVIEW)

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____
HEAD START CENTER: _____ CHILD'S HOME PHONE: _____
CHILD'S HOME ADDRESS: _____ ZIP: _____

1. IS THE CHILD NOW RECEIVING: *If "yes", include length of time receiving fluoride*
   - Topical Fluoride Applications? No ___ Unknown ___ Yes___
   - Fluoridated water? No ___ Unknown ___ Yes___
   - Fluoride Supplement diet? No ___ Unknown ___ Yes___
     (tablets____, liquid _____)

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

PART I. TO BE COMPLETED BY THE HEAD START STAFF

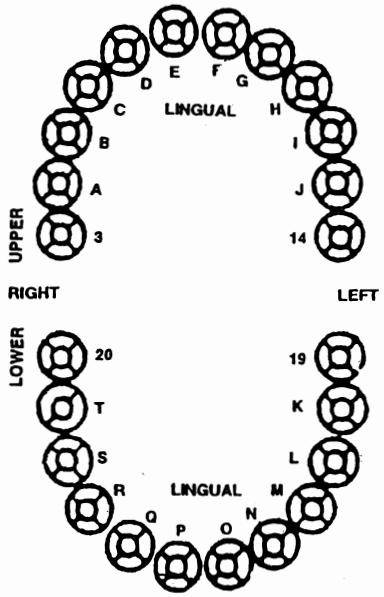
3. CHILD (___ HAS, ___ HAS NOT) PREVIOUSLY SEEN A DENTIST.
   DENTIST'S name _____ Date last visit _____
4. CHILD (___ IS, ___ IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name _____
5. CHILD (___IS, ___ IS NOT) RECEIVING MEDICATION.
   Type _____
6. CHILD IS REPORTED TO HAVE (*Give details or attach Health History, Form 2A):*

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

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or Local Agency
   - ☐ Head Start
   - ☐ In-kind Provider
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party)
8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: missing (⊗), decayed (◐), or filled (■): Indicate restorations *you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO	DAY	YR	A.D.A. Procedure Number	Actual Charges (Fee)	
		Examination					00110		
		Prophylaxis					01120		
		Topical Application					01230		
		of FLUORIDE							

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits _____ Approximate cost _____

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (___is,___is not) complete. If not, explain here, as well as items checked.
   _____
   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

   I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customery fees.
   Date _____

Dentist's Signature _____ Printed Name: _____
Office Address: _____ Office Phone: _____

ORIGINAL - to Health Coordinator

REMAINING COPY – KEEP IN CHILD'S FOLDER