Choctaw Nation Head Start

Child Oral Health Assessment

Child's Name: _____

Name of Clinic: _____ Phone: _____

Print Name

Is this Dental Exam the *first time* child has been to a Dentist? YES NO

Source of Reimbursement:

□ Sooner Care □ Indian Clinic □ Insurance □ Parent/Guardian □ Head Start

Gum Condition:

□ Normal □ Bleeds Easily □ Swollen □ Infected

Results of Dental Exam:

□ No Follow-up Treatment Needed

□ Follow-up Treatment Needed

If child needs follow up treatment, indicate what kind:

□ Preventive Treatment (Fluoride/Cleaning)

□ Fillings

□ Caps

□ Other _____

Priority Group:

□ Needs Attention Immediately

- Next appointment date: _____

□ Needs Attention Soon

- Next appointment date: _____

□ Needs Routine Care (Preventive Care)

- Next appointment date: _____

On this visit child received:

□ Topical Fluoride Application □ Cleaning □ Treatment (Fillings, Caps, Crowns)

I certify that I have completed the above service(s).

Provider Signature: _____ Date: _____

Dental Exam must be completed within 90 days of Enrollment

REV: May 2024 TL