WBC OPPORTUNITIES - HEAD START/EARLY HEAD START DENTAL RECORD

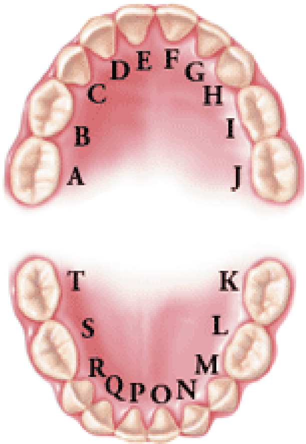
Name: ______________________________ D.O.B. ____________ Today's Date ______________

Center: ______________________ Medical Insurance ________________ Dental Insurance ______________

1. Has previously seen a dentist? Yes No.
2. Is under a physician's care? Yes No
   Physician's name: ______________________
3. Is receiving medication? Yes No
   Type: ______________________
4. Is reported to have:
   - ☐ Allergies
   - ☐ Asthma
   - ☐ Bleeding
   - ☐ Diabetes
   - ☐ Blood Transfusion
   - ☐ None of the above
   - ☐ Epilepsy
   - ☐ Heart / Vascular Disease
   - ☐ Liver Disease
   - ☐ Rheumatic Fever
   - ☐ Sickle Cell
   - ☐ HIV / AIDS
5. Has any trouble with teeth, gums or mouth that you are aware of? Yes No
6. Brushes at home? Yes No
7 Has his own toothbrush?
   Yes No
8. Is allergic to any medication?
   Yes No
9. Priority Group
   - ☐ A. Needs attention immediately
   - ☐ B. Needs attention soon
   - ☐ C. Needs routine care

10. Received instruction in Dental Hygiene? Yes No Date: ______________________
11. Received tootbrush for home use? Yes No Date: ______________________

Please indicate oral conditions before treatment: i.e., decayed,missing, or filled teeth



EXAMINATION AND TREATMENT RECORD *(List in order of need)*.

Tooth # or Letter	Surfaces	Description of Work	Date Service Performed			Procedure Number	Actual Fee
			MO	DAY	YR		
		Exam					
		Prophy					
		Fluoride					
		Bitewings					

DENTAL NEEDS IDENTFIED:

☐Treatment (restorations, pulp therapy, extraction)

☐Cleaning/Fluoride

☐Special Home Emphasis:Oral hygiene

☐Harmful Oral Habits

☐Dietary Problems

☐Other

☐No problems

ORAL HEALTH SUMMARY:

☐All planned treatment is complete, routine recall visits

☐All planned treatment is not complete. Please note date of next appointment______________________

Dentist ______________________ License # __________ Phone ______________

Address ______________________ City/Zip Code ______________________