CACS Head Start
101 E. Willow • Lansing, MI 48906
Phone: (517) 482-1504 Fax: (517) 977-9498

ORAL HEALTH FORM

Patient Information

_____ _____
Child's name Date of birth

Classroom: _____ Date of last/next dental exam: _____

Parent's/guardian's name: _____Phone: _____

Dental insurance: _____ Policy number: _____

Dental provider's name: _____

Is this dental office or clinic the child's dental home (or will be)?
☐ Yes ☐ No

Current Oral Health Status

Does the child have any teeth with white spot lesions? ☐ Yes ☐ No

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

Examination: ☐ Yes ☐ No
X-ray: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride treatment: ☐ Yes ☐ No
Dental sealants: ☐ Yes ☐ No

Referral to Specialist

☐ Yes ☐ No
_____
(*Please specify specialist*)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency Care: ☐ Yes ☐ No
Other: _____

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: _____ Next appointment: Date: _____ Time: ____

Provider's Contact Information

Dental provider's address and phone number (Print or stamp):	Name and signature of dental provider: _____ (Print name) _____ (Signature) _____ Date of service

White: Head Start Office Yellow: Dentist copy