

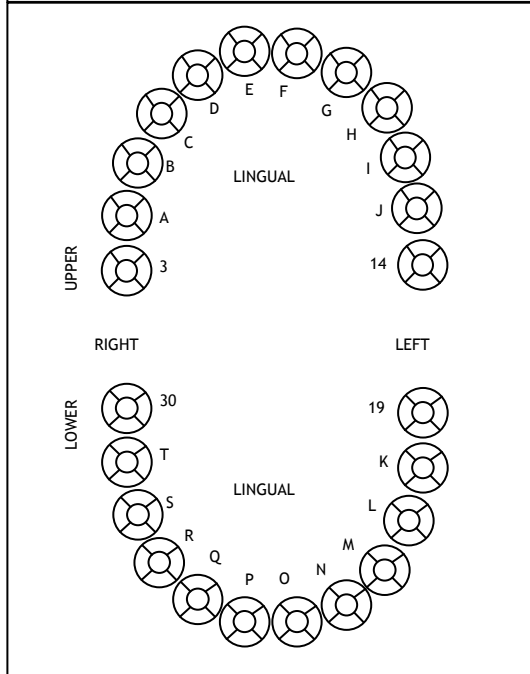
JEFFERSON COUNTY HEAD START
Serving Jefferson, Clear Creek, Gilpin, and Park counties
DENTAL HEALTH EVALUATION

CHILD'S NAME:	BIRTHDATE:	CENTER/CLASS:
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SECTION 1 - COMPLETED BY PARENT / GUARDIAN

1. Does child have any problems with his/her teeth, gums or mouth? Yes ____ No ____
If yes, please explain: _____
2. Has child previously seen a dentist? Yes ____ No ____
Dentist Name: _____ Date of last visit: _____
3. Does child's teeth get brushed daily? Yes ____ No ____
How often /when? _____
4. Is child on any medication? Yes ____ No ____ If yes, what kind? _____
5. Is child allergic to any medication? Yes ____ No ____
If yes, please explain: _____
6. Does your child have insurance? Yes ____ No ____ If yes, what kind? _____

SECTION 2 - COMPLETED BY DENTIST / DENTAL PROVIDER



Visual Screening - Date Completed: _____	
	Routine Care No Obvious Cavities
	Attention Soon Obvious cavities (# _____ of cavities)
	Urgent Care Infection or other care needed

Treatment	Date	Comments
Cleaning		
Fluoride		
X-Rays		
Fillings		
Sealants		
Extraction		
Restoration		
Treatment is complete: Yes <input type="checkbox"/> No <input type="checkbox"/>		

Please list any dental notes or additional treatment needed:

SIGNATURE OF DENTIST:	NAME OF CLINIC/OFFICE (PLEASE PRINT):	PHONE NUMBER:
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Date of most recent exam:	<input type="checkbox"/> Yes <input type="checkbox"/> No Is this the child's dental home?	Next appointment:
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