| CH   | ILD HEALTH RECORD:  |                     |                     | FORM 5, DENTAL HEALT   |                       |      |                                 |                               |                            |  |
|--|---|---------------------|---------------------|--|-----------------------|------|---------------------------------|-------------------------------|----------------------------|--|
|  | CHILD'S NAME:   |                     |                     |  | SEX: BIRTHDATE:       |      |                                 |                               |                            |  |
| A  | HEAD START CENTER:  |                     |                     | PHONE:   |                       |      |                                 |                               |                            |  |
| EW   | ADDRESS:  |                     |                     |  |                       |      |                                 |                               |                            |  |
| INTERVIEW)   | 1. IS THE CHILD  NOW RECEIVING: Topical Fluoride Application? Fluoridated water? Fluoride Supplement diet? (tablets, liquid)  If "yes," include length of time receiving fluoride  NoUnknownYes  NoUnknownYes  UnknownYes   |                     |                     | 2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?  |                       |      |                                 |                               |                            |  |
| PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER  BY HEAD START STAFF  BY HEAD START STAFF | 3. CHILD (HAS,HAS NOT) PREVIOUSLY SEEN A DENTIST.  Dentist's nameDate last visit  4. CHILD (IS,IS NOT) UNDER A PHYSICIAN'S CARE.  Physician's name.   |                     |                     | 7. SOURCE OF REIMBURSEMENT  □ EPSDT/Medicaid  □ Federal, State, or local Agency  |                       |      |                                 |                               |                            |  |
|  | Physician's name  |                     |                     | ☐ 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 |                       |      |                                 |                               |                            |  |
|  | 9. ORAL CONDITIONS BEFORE 10. EXAMINATION AND TREATMENT RECORD (List recommended services in order).  |                     |                     |  |                       |      |                                 |                               |                            |  |
|  | you perform in Item 10  | Tooth # or Surfaces | Description of Work | Т  | Treatment<br>Approved | Pe   | e Service<br>rformed<br>DAY YR. | A.D.A.<br>Procedure<br>Number | Actual<br>Charges<br>(Fee) |  |
|  | B LINGUAL M C R LINGUAL M C R LINGUAL M C R C |                     | sies to Head Stari  | l after l  | tirst visit)          |      |                                 |                               |                            |  |
|  | 11. DENTAL NEEDS (Check one or more and return 3 copies to Head Start after first visit).    A. TREATMENT (restoration,   B. CLEANING   C. FLUORIDE pulp therapy, extraction)   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.  |                     |                     |  |                       |      |                                 |                               |                            |  |
|  |   |                     | problem(s)          | s) [] 1  |                       |      | ral habi<br>oride su            | ts<br>pplement                |                            |  |
| 81 H   | oral hygiene<br>I certify that I have completed the serv  | las(a) !!st-d!-     | Port II Itom 40 -   | nd the   |                       | haro | م ماه عمد                       | int                           |                            |  |