NEICAC HEAD START

Dental Form

Yearly dental exams are required by NEICAC Head Start

Date of Service: _____

Child's name: _____ **Date of birth:** _____

This practice is the child's dental home: Yes No
This child had previous dental care: Yes No

Oral Health Care Services Delivered During Visit

(*Please be as specific as possible)*

Diagnostic/Preventative Services

Examination:	☐Yes	☐No
X-rays:	☐Yes	☐No
Cleaning:	☐Yes	☐No
Fluoride varnish:	☐Yes	☐No
Dental sealants:	☐Yes	☐No

Other: _____

Restorative/Emergency Care

Fillings:	☐Yes	☐No
Silver diamine fluoride:	☐Yes	☐No
Crowns:	☐Yes	☐No
Extractions:	☐Yes	☐No
Emergency Care:	☐Yes	☐No

Other: _____

☐ Referral to Specialty Care Clinic _____

☐ Sedation required for treatment: Location _____

Future Oral Health Care Services

Treatment completed today: ☐No ☐Yes Routine recall exam date: _____

If no: Next appointment date: _____ Services needed: _____

Additional Comments or Information

Practice name: _____ Provider Name: _____
please print

Provider Signature: _____ Date: _____