CHILD HEALTH RECORD:

DUPLIN COUNTY SCHOOLS
PREKINDERGARTEN PROGRAM

FORM 5, DENTAL HEALTH

(COMPLETE AT INTERVIEW)

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____

HEAD START CENTER: _____ PHONE: _____

ADDRESS: _____

1. IS THE CHILD NOW RECEIVING:
   Topical Fluoride Application? *If "yes" include length of time receiving fluoride*
   No ____ Unknown ____ Yes ____
   Fluoridated water?
   No ____ Unknown ____ Yes ____
   Fluoride Supplement diet?
   No ____ Unknown ____ Yes ____
   (tablets _____, liquid _____)

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

PART 1. TO BE COMPLETED BY HEAD START STAFF

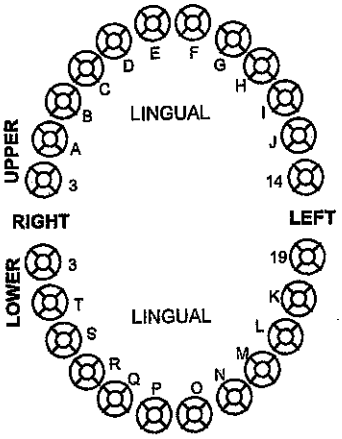
3. CHILD (____ HAS, ____ HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name _____
4. CHILD (____ IS, ____ IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name _____
5. CHILD (____ HAS, ____ HAS NOT) RECEIVING MEDICATION.
   Type _____
6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___	_____		
Heart/Vascular Dis.	___	___	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State or local Agency _____
   - ☐ 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

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (◪), or filled (■), indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Latter	Surface	Description of Work	Treatment Approved	Date Service Performed MO. DAY YR.	A.D.A. Procedure Number	Actual Charges (Fee)

11. DENTAL NEEDS (Check one or more and return 3 copies to Head Start after first visit).
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits _____. Approximate cost _____.

12. CHILD 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.
   _____
   _____
   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietry problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs Fluoride supplement

I certify that I have completed the service(s) listed in Part II, item 10, and that itemized charges do not exceed my usual and customary fees.

Signature _____ Date _____