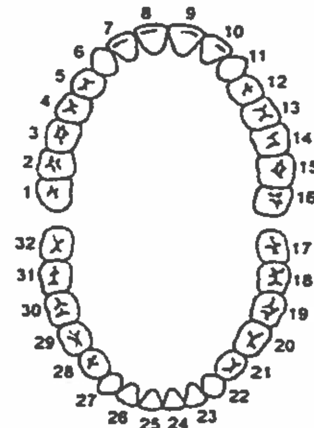
EXAMINATION AND TREATMENT RECORD

List Recommended Services in Order

ORAL CONDITIONS BEFORE TREATMENT:

Missing ○ Decayed ● Filled ○



Indicate restorations you perform as listed below.

Priority Group: ________Needs Attention Immediately
________Needs Attention Soon
________Needs Routine Care

Dental Needs: ________Treatment (restoration, pulp therapy, extraction)

________Cleaning ________Fluoride
________Other ________No Problem

Tooth/ Letter	Surfaces	Description of Work	Treatment Approved	Date Services Performed			ADA Procedure #	Actual Charge

Approximate number of Visits: ____________________ **Approximate Cost:** ____________________

This is an accurate description of services required.

Dentist Signature: ________________________________

All planned treatment **IS** ☐ **IS NOT** ☐ complete. If not, explain here:

The following records were provided. Explanation on each included with this report.

________Routine recall visits ________Special home emphasis, oral hygiene
________Dietary problem(s) ________Development problem(s)
________Harmful oral habit ________Needs fluoride treatment

I certify that I have completed the service(s) listed on this page and the services as marked.
Itemized charges do not exceed my usual and customary fee.

Dentist Signature: ________________________________ **Date:** ____________

This is an OPTIONAL SUPPLEMENTAL FORM provided by the Ohio Department of Education that may be used to comply with the HEAD START PERFORMANCE STANDARDS regarding dental intervention and data (45 CFR 13043-3,4,2). PROGRAMS MAY OR MAY NOT CHOOSE TO USE THIS FORM. The annual dental exam by a dentist is an oral diagnostic procedure which should include radiographs (x-rays) only if the dentist determines that they are absolutely necessary. This should be completed within 60 days of the child's entrance into the program. Developmental dental history should be part of health screening completed within 45 days of entrance.

OHIO DEPARTMENT OF EDUCATION
DIVISION OF EARLY CHILDHOOD EDUCATION
DENTAL FORM

Child's Name: ______________________________ Male ________ Female ________

Date of Birth: ____________________ Child's Current Age: __________

Parent/Guardian Name: ____

1. Is the child receiving any of the following? If "yes" include length of time receiving fluoride.
   Topical fluoride application ______**Yes** ______**No** ______**Unknown**
   Fluoridated water ______**Yes** ______**No** ______**Unknown**
   Fluoride supplement diet ______**Yes** ______**No** ______**Unknown**
   ______**Tablets**
   ______ **Liquid**

2. Does the child have any of the following? If "yes" provide details.
   Allergies ______**Yes** ______**No**
   Asthma ______**Yes** ______**No**
   Bleeding ______**Yes** ______**No**
   Diabetes ______**Yes** ______**No**
   Epilepsy ______**Yes** ______**No**
   Heat/Vascular Disease ______**Yes** ______**No**
   Liver Disease ______**Yes** ______**No**
   Rheumatic Fever ______**Yes** ______**No**
   Sickle Cell Disease ______**Yes** ______**No**
   Other (Please List) ____

3. Does your child have trouble with teeth, gums or mouth? ______Yes ______No
   If so, please explain. ____

4. Has your child previously seen a dentist? ______Yes ______No
   Dentist Name: ______________________________ Date of last visit: ________________

5. Is your child receiving medication? ______Yes ______No
   Physician Name: ______________________________

6. Is your child receiving medication?

7. **PLEASE PROVIDE A WRITTEN SUMMARY OF SERVICES REQUIRED (ON THE BACK OF THIS FORM)**
   - for the relief of pain or infection
   - restoration and/or pulp therapy of decayed primary and permanent teeth
   - extraction of non-restorable teeth
   - dental prophylaxis and instruction in self-care oral hygiene pro

Please Print

Dentist Name			
Complete Address			
Phone			
License Number		**Tax ID #**	