

# Head Start Child Oral Health Assessment

Date of Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_

Completed By:  Head Start Staff

Name: \_\_\_\_\_

Dental Provider

Name: \_\_\_\_\_

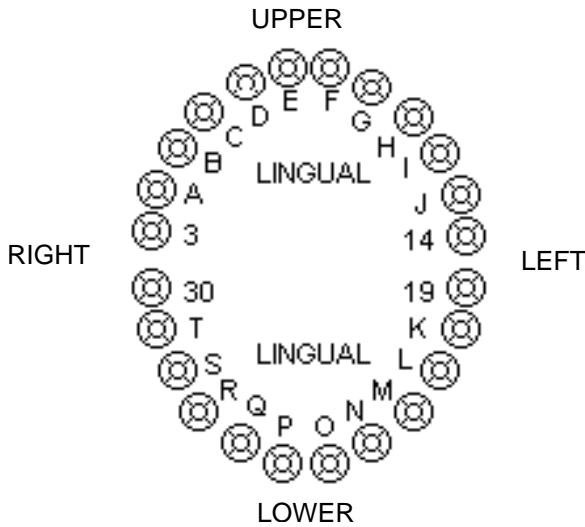
Provider Setting:  Home  
 Employment

Dental Office/Clinic       School/Center  
 Other: Specify \_\_\_\_\_

Evaluation Type:  Screening

Assessment

**ORAL CONDITION**



**Key:**    Missing    Decayed    Filled

**Comments:**

Number of times per day child brushes teeth: |\_\_| |\_\_|    Flossing frequency  Daily    Weekly    Occasionally    Never

Gum Condition:     Normal                       Swollen                       Bleeds Easily                       Infected

Received Fluoride Treatment?    Yes    No            Received Cleaning?    Yes    No

Dental Needs:

No Needs                       Treatment                       Cleaning

Fluoride Supplement                       Oral Hygiene Instruction

Other: Specify \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\* Please use back of form for general comments.