



Head Start Oral Health Form—Pregnant Women

Patient Information

Patient's name _____ Date of birth _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

Date of Exam and/or Treatment _____ / _____ / _____ This practice is the patient's dental home: Yes No

Current Oral Health Status

Does the patient have any teeth with untreated decay? Yes (decay) No (decay free)

Does the patient have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? Yes No

Does the patient have gum disease? Yes No

Are there treatment needs? Yes, urgent Yes, not urgent No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services	Counseling/Anticipatory Guidance	Restorative/Emergency Care
Examination: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fillings: <input type="checkbox"/> Yes <input type="checkbox"/> No
X-rays: <input type="checkbox"/> Yes <input type="checkbox"/> No		Crowns: <input type="checkbox"/> Yes <input type="checkbox"/> No
Risk assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral to Specialty Care	Extractions: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cleaning: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency care: <input type="checkbox"/> Yes <input type="checkbox"/> No
Fluoride varnish: <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Other: _____
Dental sealants: <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>(Please specify specialist)</i>	<i>(Please specify)</i>

Future Oral Health Care Services

All treatment completed: Yes No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? Yes No

If yes: Approximate number of appointments needed: _____ Next appointment: Date: _____ Time: _____

Additional Information for Patient, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

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