West River Head Start

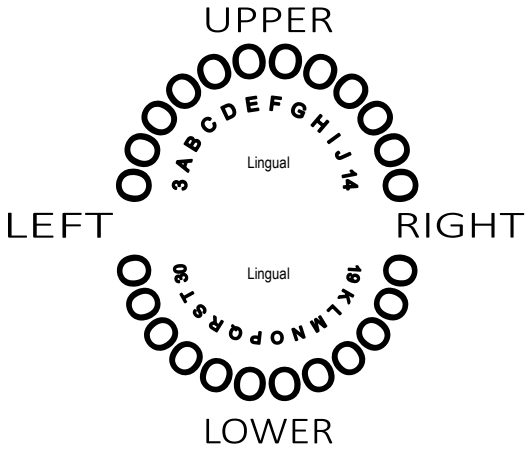
DENTAL EXAM / ORAL HEALTH FORM

Patient Information

Child's Name:	Child's DOB:	Date of Exam:

Current Oral Health Status

ORAL CONDITION	
Missing	⊗
Decayed	≋
Filled	●



Number of times per day child brushes teeth: _____

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

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

Oral Health Care Services Delivered During Visit

Diagnostic / Preventive Services

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

Counseling / Anticipatory Guidance

Yes ☐ No ☐

Referral to Specialty Care

Yes ☐ No ☐

_____
(Please specify specialist)

Restorative / Emergency Care

Fillings: Yes ☐ No ☐
Crowns: Yes ☐ No ☐
Extractions: Yes ☐ No ☐
Emergency care: Yes ☐ No ☐
Other: _____
(Please specify)

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 parent, head start staff, and medical providers:

Oral Health Provider's Contact Information and Signature

Provider Name (printed)	Phone Number	Fax Number

Provider Signature	Date	Address

Please return form to:

	West River Head Start 1004 7th Street SW Mandan, ND 58554 Tel (701) 663-9507	West River Head Start PO Box 197 Carson, ND 58529 Tel (701) 622-3505	West River Head Start PO Box 116 New Salem, ND 58563 Tel (701) 843-8061

Fax number for all WRHS locations: 701-663-9643

Revised 4/4/2025