Absaroka Inc.

Head Start Dental Examination

CHILD'S NAME:________________________	DATE OF SERVICE:____________
SEX:________ BIRTHDATE:____________________	

To be completed by Head Start Staff or Dental Clinic Staff

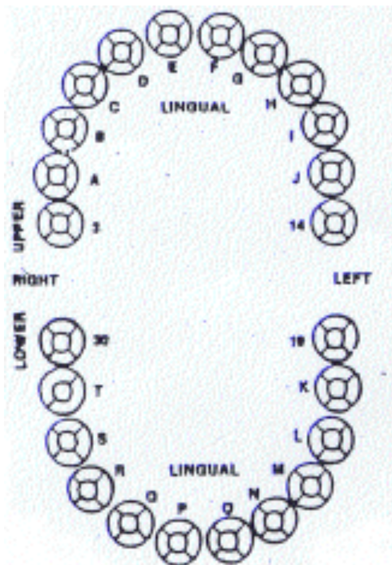
Is the child now receiving either of the following ?

Topical fluoride application	Yes	No	Unknown
Fluoride supplements	Yes	No	Unknown

Is the child's primary source of drinking water fluoridated? Yes No Unknown

Specify source: City water Well water (fluoride level__________)
Bottled water

Treatment Received Today



Tooth # or Letter	Description of work

Education provided at this visit

- Oral Hygiene
- Dietary Issues
- Harmful oral habits
- Fluoride

Dental Needs *To be completed by Dental Clinic*

- Routine recall visits
- Treatment (restoration, pulp therapy, extraction)
- Cleaning
- Fluoride supplements at home (prescription provided)
- Other (specify):______________________________

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Expected date of next visit:________________________

I certify that I have completed the services listed above.

______________________________ ____________________

Dentist Signature **Date**