Wood County Preschool Program

DENTAL FORM

(Required of ALL children every 13 months)

_____ _____ ❒ M ❒ F _____

Child DOB Parent/Guardian

1. Is the child now receiving any of the following? If "yes," include length of time receiving fluoride.
   ❒ Y ❒ N ❒ Unknown Topical fluoride application ❒ Y ❒ N ❒ Unknown Fluoridated water
   ❒ Y ❒ N ❒ Unknown Fluoride supplement diet ❒ Tablets ❒ Liquid

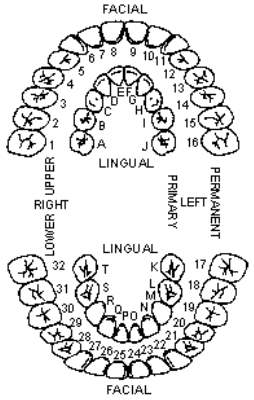
2. Does the child have any of the following? If so, please provide details. ❒ Allergies ❒ Sickle cell disease
   ❒ Epilepsy ❒ Asthma ❒ Liver disease ❒ Heart/Vascular disease
   ❒ Bleeding ❒ Diabetes ❒ Rheumatic fever ❒ Other (please list) _____

3. If the child has any trouble with teeth, gums, or mouth, please describe: _____

4. Child has previously seen a dentist? ❒ Y ❒ N Dentist name _____ Date last visit _____

5. Child is receiving medication? ❒ Y ❒ N

6. Please provide a WRITTEN SUMMARY OF SERVICES REQUIRED below:
   • for the relief of pain or infection • restoration and/or pulp therapy of decayed primary and permanent teeth
   • extraction on non-restorable teeth • dental prophylaxis and instruction in self-care oral hygiene procedures



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
p Fluoride ❒ No Problem ❒ Other: _____

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

Approximate number of visits: _____ (This is an accurate determination of services required.)

All planned treatment (❒ is ❒ is not) complete. If not, explain here:

The following services were provided.
- ❒ Routine recall visits
- ❒ Dietary problem(s)
- ❒ Harmful oral habit

Explanation of each included with this report.
- ❒ Special home emphasis, oral hygiene
- ❒ Developmental problem(s)
- ❒ Needs fluoride supplemen

Dentist Name (print) _____ **License No.** _____

Address _____ **Phone** _____

City/State/Zip _____ **Tax ID No.** _____

SIGNATURE OF DENTIST _____ **DATE OF EXAM** _____

Parents: If you pick up form from dentist, please give to your child's teacher or you/dentist may send it to:

Wood County ESC
1867 North Research Drive
Bowling Green, Oh 43402

FAX Number: 419-354-1146
(Attn: PS Secretary)

or email to:
nstickles@wcesc.org

This is a sample form provided by the Ohio Department of Education that may be used to comply with the Head Start Performance Standards regarding dental examination and the data (45 CFR 1304.3 -3,4,5). 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. Developmental dental history should be part of health screening completed within 45 days of entrance.