

School Year: _____

WOOD COUNTY EDUCATIONAL SERVICE CENTER
Wood County Preschool Program

Preschool Dental Form
(Required of ALL children every 13 months)




Child _____ M F _____
DOB _____ Parent/Guardian _____

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

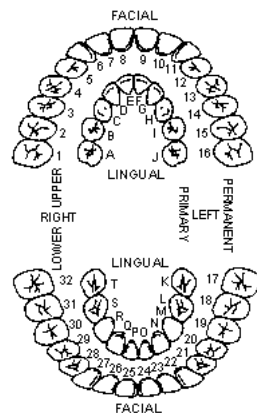
EXAMINATION AND TREATMENT RECORD

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
 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 (<input type="checkbox"/> is <input type="checkbox"/> is not) complete. If not, explain here: The following services were provided. <input type="checkbox"/> Routine recall visits <input type="checkbox"/> Dietary problem(s) <input type="checkbox"/> Harmful oral habit	Explanation of each included with this report. <input type="checkbox"/> Special home emphasis, oral hygiene <input type="checkbox"/> Developmental problem(s) <input type="checkbox"/> Needs fluoride supplement
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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 **FAX Number: 419-354-1146** or email to:
1867 North Research Drive **(Attn: PS Secretary)** **preschool@wcesc.org**
Bowling Green, Oh 43402

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.