ORAL HEALTH ASSESSMENT/DENTAL EXAM

Community Action Team
Child & Family Development Programs
PO Box 10, Rainier, OR 97048

_____ Child's Name _____ _____ Date of Birth Site	OHP # _____ DCO _____ Private _____ None _____

1. Has your office provided any type of dental services for this child: □ Yes □ No
   (If yes, please continue, otherwise please fax back to Head Start)

2. Are you this child's primary dental provider: □ Yes □ No

3. Date of Last Exam _____ Date of next Exam_____
   Child is up-to-date with care: □ Yes □ No
   Treatment or Follow-up needed: □ Yes □ No
   Date of Follow-up if applicable:_____

4. Child approved for fluoride □ Yes □ No
   Date Applied: _____
   Date Applied: _____
   Date Applied: _____

   Did the child receive preventive care (Fluoride varnish or Cleaning)?
   □ Yes □ No

5. **ASTDD/Basic Screening Survey** indicators:

   Child has cavities: □ Yes □ No Child has treated decay (fillings): □ Yes □ No

   Child has ECC (current or past decay in upper anterior teeth): □ Yes □ No

   Treatment Urgency:

   - □ (0) No obvious problems
   - □ (1) Early Dental Care needed
   - □ (2) Urgent Care needed (pain/infection)

Additional comments: _____

_____

Thank-you for your partnership! We appreciate all you do for children and families in our community.

Return to: Head Start
FAX #:

_____ _____
Dental Care Provider Signature **Date**