Alachua County Public Schools
Head Start Program

Dental Health Record / Permission

Part I: Parent/Guardian to Complete

Child:_____ Birthdate:_____ Center:_____

I give permission for my child to have his/her teeth examined by a dentist. I understand prophylactic care which may include cleaning, fluoride, and x-rays may be performed.

Signature of Parent;/Legal Guardian:_____ Date:_____

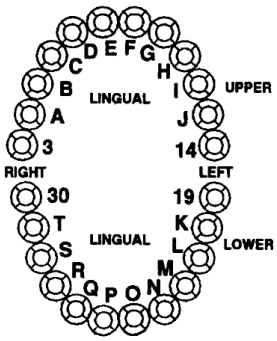
1. Child ☐ has ☐ has not previously seen a dentist
   Dentist's Name:_____ Date Last Visit:_____
2. Is the child now receiving: Topical Fluoride Application ☐ Yes ☐ No ☐ Unknown
   Fluoridated Water? ☐ Yes ☐ No ☐ Unknown
   Fluoride: ☐ Tablets ☐ Liquid
   Length of Time Receiving Fluoride:_____
3. Does child have any trouble with teeth, gums, or mouth?_____
4. Child is reported to have (give details or attach health history):
   Allergies ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Heart/Vascular Disease ☐ Yes ☐ No
   Asthma ☐ Yes ☐ No Epilepsy ☐ Yes ☐ No Rheumatic Fever ☐ Yes ☐ No
   Bleeding ☐ Yes ☐ No Liver Disease ☐ Yes ☐ No Sickle Cell Disease ☐ Yes ☐ No
   Other: ☐ Yes ☐ No List::_____
5. Child ☐ is ☐ is not under a doctor's care.
   Doctor's Name:_____ Dental Insurance:_____
6. Child ☐ is ☐ is not taking medication: List:_____

-- Continue on Next Page --

<u>Part II</u>: Dental Provider to Complete

7. Oral Condition Before Treatment:

Missing ○ Decayed ○ Filled ○
(Indicate restorations you perform in Item 8)



8. Examination and Treatment Record *(List recommended services in order)*

Tooth # or Letter	Surfaces	Description of Work	Date of Service Performed	ADA Procedure Number	Actual Charge

9. Source of Reimbursement for Services

☐ EPSDT/Medicaid ☐ Head Start ☐ Other:_____

10. Dental Needs (Check one or more) Return one copy to the Head Start Health Coordinator after exam/first visit.)

☐ Cleaning ☐ Fluoride ☐ Treatment (restoration, pulp therapy, extraction)

☐ No Problems ☐ Other:_____

Completed by:_____ Date:_____

11. Priority Group

☐ Needs Attention Immediately ☐ Needs Attention Soon ☐ Needs Routine Care

12. Child's Oral Health Summary (Complete and return two copies to Head Start after the final visit.)

All planned treatment ☐ is ☐ is not complete. If not complete, explain here, as well as items checked below:_____

☐ Special home emphasis on oral hygiene ☐ Routine recall visits ☐ Dietary problem(s)

☐ Developmental problem(s) ☐ Harmful oral habits ☐ Needs fluoride supplement

I certify that I have completed the service(s) listed in Part II, Item 8, and that itemized charges do not exceed my usual and customary fees.

Signature of Dentist:_____ Date:_____