Oral Health Form

Child's Name: _____ DOB: _____

During Visit: Oral Health Services Provided

Diagnostic/Preventative Services provided: ☐ YES ☐ NO

Counseling/Anticipatory Guidance provided: ☐ YES ☐ NO

Restorative/Emergency Treatment provided: ☐ YES ☐ NO

If yes, please select the treatment provided: __Filings __Crowns __Extractions __Other

Referral to Specialty Care provided: ☐ YES ☐ NO

_____

(Please specify specialist)

Future Oral Health Care Services:

All treatment is completed: ☐ YES ☐ NO

More appointments needed for treatment (Restorative, Pulp, etc.): ☐ YES ☐ NO

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Next recall date: _____ / _____ (month/year)

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

_____ _____ _____

Provider name *(please print)* Phone number Fax number

_____ _____

Practice name Address

_____ _____

Provider signature Date of service

7880 Lincole Place-Lisbon, OH 44432 Phone: 330-424-6693 Fax: 330-424-4182