Child's Dental Exam Form

Child's Name:_____ **DOB:**_____ **Exam Date:**_____
(LAST/FIRST)

PARENT'S CONSENT (to be completed by PARENT)

I authorize Head Start staff, the Dental Provider, and the SF Dept. of Public Health to exchange any health-related information from this dental exam to improve dental care services. I understand that all information will be kept confidential.

_____ _____
Parent/Guardian Signature **Date**

Dental Provider's Name: _____ Dental Provider Signature: _____
(Please Print or Stamp) Provider Phone #: _____

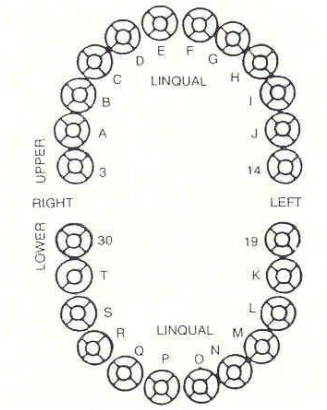
□ Bayview Child Health Ctr	□ Native American Health Ctr.	□ UCSF Hospital or Clinic
□ Bayview/HP Dental Clinic	□ NEMS	□ UOP Dental Clinic
□ Children's Choice	□ Potrero Hill Health Ctr.	□ Western Dental
□ Chinatown Public Health Ctr.	□ Silver Ave Family Health Ctr.	□ ZSFG, SFGH, or SF General
□ HealthRight 360	□ Southeast Health Ctr.	
□ Mission Neighborhood Health Ctr.	□ South of Market Health Ctr.	□ Other: _____

DENTAL PROVIDER'S REPORT (to be completed by DENTAL PROVIDER)

Do not omit any information on this form.

FINDINGS (Please indicate recommended follow-up treatment below):

_____**CLASS 1: HEALTHY**: No visible cavities, within normal limits.
_____**CLASS 2: VISIBLE DECAY:** Need dental treatment as soon as possible.
_____**CLASS 3: URGENT**: Large visible cavities, pain, infection, and swelling. Immediate treatment needed.



Tooth # or letter	Surfaces	Description of services completed at this visit

Prophylactic Services Provided:

□ Visual Exam □ Fluoride Application □ Cleaning
□ X-Rays □ Silver Diamine Fluoride

□ Other, please specify: _____

Recommended Follow-Up:

____ **A. Treatment.** Please describe: _____

□ All treatment is complete

□ Treatment is NOT complete

Number of follow-up visits needed? _____

Follow-Up Appointment (Date/Time): _____

____ **B. Routine Follow-Up:** Cleaning and fluoride. Follow-Up Appointment (Date/Time): _____

____ **C. Other** _____

What oral health education did you provide to the child/caregiver? Please circle:
a. oral habits (ex: thumb sucking) b. diet c. oral hygiene d. other_____