FORM N-3

Stockbridge-Munsee Community | Electa Quinney Head Start
CHILD HEALTH RECORD-DENTAL EXAMINATION

Child's Full Name **Date of Birth**

Date

Dentist's Name **Date of Last Dental Exam**

Check Services Child is NOW RECEIVING ☐ - Fluoride Application ☐ - Fluoridated Water ☐ - Fluoride Supplement Diet

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☐ - Yes ☐ - No Does the child have any trouble with teeth, gums, or mouth that the parents are aware of

☐ - Yes ☐ - No Has the child previously seen a dentist

☐ - Yes ☐ - No Is the child currently under a physician's care

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Child is Reported to Have

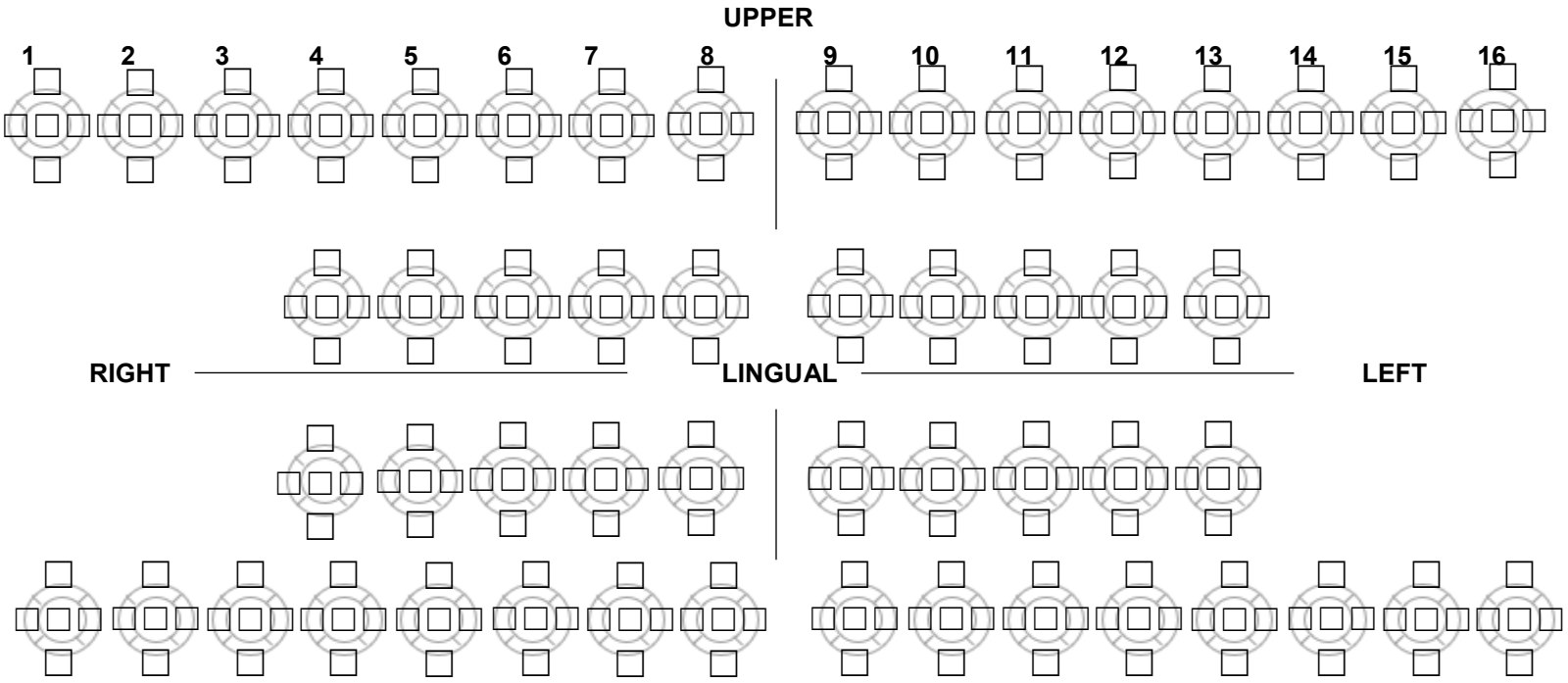
☐ - Allergies ☐ - Asthma ☐ - Bleeding ☐ - Liver Disease

☐ - Diabetes ☐ - Heart/Vasc Dis ☐ - Rheumatic Fever ☐ - Sickle Cell Disease

☐ - Other

Oral Conditions BEFORE Treatment

☐ - Missing ☐ - Decayed ☐ - Filled



FORM N-3

Dental Needs

☐ **- Treatment (Restoration, Pulp Tx, Extraction)** ☐ **- Cleaning**

☐ **- Fluoride** ☐ **- Other Please List**

Approximate Number of Visits Required

Recommended Follow-Up

☐ **- Routine Recall Visits**

☐ **- Specific Home Emphasis, Oral Hygiene**

☐ **- Dietary Problems**

☐ **- Developmental Problems**

☐ **- Harmful Oral Habits**

☐ **- Needs Fluoride Supplement**

☐ **- Has Completed Treatment** ☐ **- Has NOT Completed Treatment**

I Hereby Certify that I have Completed the Service(s) Listed Above and the Itemized Charges Do Not Exceed Usual and Customary Fees

SIGNATURE

Dentist Signature **Date of Examination**