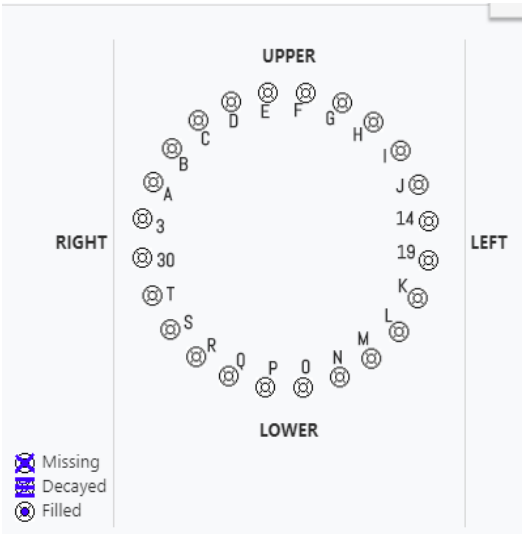
Region 14/15 Head Start / Early Head Start
Oral/Dental Exam

Date of exam: ____/____/____

Name: _____DOB_____

Early Head Start and Head Start Programs are required to obtain a statement from a dental healthcare professional determining whether a student is up-to-date on a schedule of age appropriate preventive oral health care. The Texas Health Steps Dental Periodicity Schedule is utilized to determine age appropriate.

Is this practice the child's dental home?
Yes____ No_____



Oral/Dental Health Care Services completed during visit:

Examination:			**Yes**	**No**		
Preventative Services Received?			**Yes**	**No**		
Cleaning:	Yes	No	Risk Assessment:		Yes	No
Fluoride varnish:	Yes	No	X-rays:		Yes	No
Dental sealants:	Yes	No				
Dental Treatment Needed?			**Yes**	**No**		
Dental Treatment Received?			**Yes**	**No**		
All treatment completed?			**Yes**	**No**		
More appointments needed for treatments?			Yes	No		

- **Next appointment for treatments:** Date_____Time_____

Referred to: _____

Comments:_____

_____

_____

Next routine appointment date: _____ Time_____
(Every 3-6 months)

Provider Signature _____ Date _____

Print Provider Name _____

Address_____Phone_____

Head Start Use Only: Date received_____Initial_____

Form Updated 7/2019