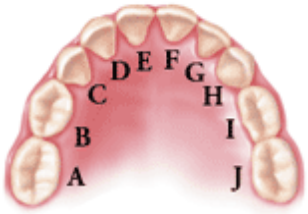
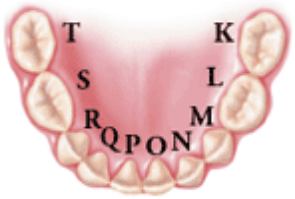
**NEW WBC OPPORTUNITIES - HEAD START 0-5**
**DENTAL RECORD**

Name: _____ D.O.B. _____ Date of Exam_____

Center: _____Medical Insurance _____ Dental Insurance_____

**Please indicate oral conditions before treatment: i.e., decayed,missing, or filled teeth**




| EXAMINATION AND TREATMENT RECORD *(List in order of need)*. | | | | | | | |
|---|---|---|---|---|---|---|---|
| Tooth # or Letter | Surfaces | Description of Work | Date Service Performed | | | Procedure Number | Actual Fee |
| | | | MO | DAY | YR | | |
| | | Exam- Preventative cleaning (aka prophy)& fluoride | | | | | |
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| | | | | | | | |
| | | Treatment | | | | | |
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Currently on any medications? Yes No

Type: _____

Is allergic to any medication? Yes No

Has had any trouble with teeth, gums or mouth that you are aware of? Yes No

Using a pacifier or drinking from a bottle? Yes No

**DENTAL EDUCATION:**

☐Preventative Cleaning and Flouride
☐Fluroide Prescribed
☐Dietary Problems
☐Special Home Emphaisis: Oral Hygiene
☐Developmental Problems (Speech)
☐ Demonstrate proper technique (when to get a new toothbrush etc)
☐Harmful Oral Habits
☐Other _____
☐Explanation of Treatment (restoration, pulp therapy (root canal),extraction, etc)

**DENTAL SERVICES COMPLETED:**

☐ Cleaning (Prophy) & Flouride Completed at this appointment. Next 6 month appointment is: _____

☐ Treatment Completed (restoration, pulp therapy (root canal),extraction, fillings)

☐ Treatment Not Completed. Date of next appointment(s) is/are_____

☐ Referral needed for Pediatric Anesthesiologists. My recommendation is: _____

Any dental concerns or recommendations: _____

_____

Dentist _____ Phone _____

Address_____ City/Zip Code_____

WBCO, Head Start Administrative Office - Questions: Health Coord. at (512)763-1400; Fax to : _____ Center _____