



# TLINGIT & HAIDA HEAD START

*Central Council Tlingit and Haida Indian Tribes of Alaska*

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 Phone 907.463.7127 • Toll Free 800.344.1432 • Fax 1.877.389.7796 • www.ccthita.org

## DENTAL EXAMINATION REPORT

(Head Start requires complete annual dental/oral health exam documentation as necessary in order to provide prompt assistance to families to best meet the oral health care needs of the child. Please complete all boxes, sign, date and provide a copy to parent/guardian and **FAX a copy to Tlingit & Haida Head Start at 1-877-389-7796**).

Child's name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_ Telephone/Cell number: \_\_\_\_\_

Head Start Site/Community: \_\_\_\_\_

Child is a regular patient at this office (dental home):  Yes  No  Episodic  First visit with this office

### Diagnostic and Preventive Procedures Performed:

Clinical Examination  Cleaning  Fluoride  Sealants  X-Rays

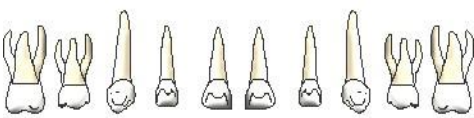

### Current Oral Health Status:

**Caries Risk Status:**  High  Moderate  Low

**Cavities:** \_\_\_\_\_ (how many)

Gums and supporting tissues:  Healthy  Mild Gingivitis  Moderate Gingivitis  Severe Gingivitis

Other Findings: \_\_\_\_\_

Recommendations:	Restorative/Emergency Care:
<input type="checkbox"/> No further treatment needed at this time. <input type="checkbox"/> Additional treatment is required. <input type="checkbox"/> Return to clinic in _____ months for an exam.  <b>Anticipatory Guidance:</b> <input type="checkbox"/> Diet (sugary drinks) <input type="checkbox"/> Teeth brushing <input type="checkbox"/> Flossing <input type="checkbox"/> Other: _____	<div style="display: flex; justify-content: space-between; font-size: small;"> <span>A B C D E F G H I J</span> <span><input type="checkbox"/> Fillings _____</span> </div>  <div style="display: flex; justify-content: space-between; font-size: small;"> <span>T S R Q P O N M L K</span> <span><input type="checkbox"/> Crowns _____</span> </div>  <div style="display: flex; justify-content: space-between; font-size: small;"> <span></span> <span><input type="checkbox"/> Extractions _____</span> </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <span></span> <span><input type="checkbox"/> Emergency care _____</span> </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <span></span> <span><input type="checkbox"/> Other _____</span> </div>
<b>Referral to Specialty Care:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="float: right;"><i>(Please Specify Specialty)</i></span>	

\_\_\_\_\_  
Dentist name (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Exam Date

\_\_\_\_\_  
Clinic Name, Address, City

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Parent/Legal Guardian Signature Authorizing Release

\_\_\_\_\_  
Date: