SETA HEAD START
DENTAL HEALTH RECORD

Child's Name:________________________________ DOB:__________ M__ F__ Center:__________________________

Parent/Guardian Name: ____ Phone: ________________________________

Address:____

I authorize professionally qualified individuals to exchange information about my child. I understand that all information will be kept in a confidential file.

Parent/Guardian Signature____ Date:___________________

TREATMENT NEED SUMMARY

A. Please list recommended services in order on the table below and restoration(s) you performed:

UPPER — RIGHT — LEFT — LOWER — LINGUAL — LINGUAL
Upper: 3, A, B, C, D, E, F, G, H, I, J, 14
Lower: 30, T, S, R, Q, P, O, N, M, L, K, 19

Tooth # or letter	Surfaces	Description of services	Date of service

Cleaning and fluoride treatment date completed ____________

B. In diagram above indicate, oral conditions **before treatment**: Missing Decayed Filled

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CHILD ORAL HEALTH SUMMARY

C. Dental Needs

☐ Routine recall visits ☐ Special home emphasis, oral hygiene

D. Problems Noted

☐ Dietary ☐ Harmful oral habits
☐ Developmental ☐ Other_____________

E. All planned treatment:

☐ Is complete ☐ Is not complete.

If treatment is not complete, please specify pending treatments; **Date of next appointment:** _____/_____/_________

☐ Treatment (e.g. restoration, extraction) ☐ X-rays ☐ Cleaning ☐ Fluoride ☐ Sealant(s) ☐ Other ____________

Please return completed forms to the parent/guardian or send to: SETA Head Start, 925 Del Paso Blvd., Suite 200, Sacramento, CA 95815. Phone: (916) 263-3804

Dentist ____ Signature______________________________________

Date ________________ Phone_______________________ Address____

Distribution: White: Child's File Blue: Parent

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