SETA HEAD START
DENTAL HEALTH RECORD

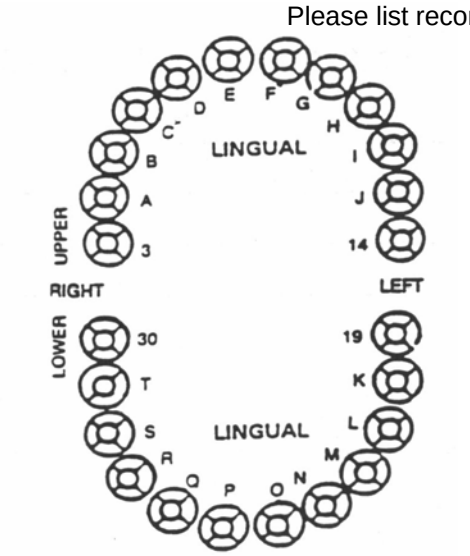
Child's Name:_____ DOB:_____ M__ F__ Center:_____

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:_____

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



Tooth # or letter	Surfaces	Description of services	Date of service

Cleaning and fluoride treatment date completed _____

In diagram above indicate oral conditions before treatment: Missing ⊗ Decayed ◎ Filled ●

CHILD ORAL HEALTH SUMMARY

Dental Needs
☐ Routine recall visits ☐ Special home emphasis, oral hygiene

Problems Noted
☐ Dietary ☐ Harmful oral habits
☐ Developmental ☐ Other_____

All planned treatment:
☐ Is complete

☐ Is not complete. Please explain and check one or more below:
☐ Treatment (restoration, pulp therapy, extraction) ☐ X-rays ☐ Cleaning

☐ Fluoride ☐ 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: 263-3804

Dentist _____ Signature_____

Date _____ Phone_____ Address_____

Distribution: White: Child's File Blue: Parent
Revised 11/07