Head Start Oral Health Form—Pregnant Women and Pregnant People

Patient Inform	ation								
Patient's name					Date of birth		Phone number		
Address					City		State Zi	p code	
This practice is the	patient	's dental h	ome:	Yes No					
Current Oral H	ealth S	tatus							
Does the patient had been the patient had been the patient had been the patient had been there treatment.	ave any Yes ave gur	teeth that No n disease?	have pre	•	n treated for decay, in		owns,		
Oral Health Ca	re Serv	rices Deli	vered Du	uring Visit					
Diagnostic/Preventive Services			Counseling/Anticipatory Guidance			Restorative/Emergency Care			
Examination:	Yes	No	Yes	No		Fillings:	Yes	No	
X-rays:	Yes	No	Defe	- 4 - C - -	.lkC	Silver diamine	Yes	No	
Risk assessment:	Yes	No		al to Specia	lity Care	fluoride:			
Cleaning:	Yes	No	Yes	No		Crowns: Extractions:	Yes Yes	No No	
Fluoride varnish:	Yes	No	(Dlogso	specify speci	alist)	Emergency care		No	
Silver diamine fluoride:	Yes	No	(Fleuse	зреспу зресп	unst)	Other:	. 103	110	
Dental Sealants:	Yes	No				(Please sp	pecify)		
He	alth Ca	re Servic	es						
All treatment comp More appointment If yes: Approximate	ts neede			Yes No needed:		l date: / nt: Date:	·	month/yea	
Additional Info	ormatio	on for Pa	tient, He	ad Start St	aff, and Medical P	roviders			
Oral Health Pro	ovider'	s Contact	Informa	ation and S	Signature				
Provider name (please print)				Phone number			Fax number		
Practice name					Address				
Provider signature					Date of service				