LSUHealthNewOrleans
HEALTH SCIENCES CENTER
School of Allied Health Professions
Human Development Center

Early Head Start Child Care Partnership

Dental Form

Dear Health Provider,
LSUHSC's Early Head Start is a federally funded child development program which strives to ensure that all enrolled children are up-to-date on medical and dental health screenings. We ask that you fill out the following information for the child named below who is enrolled in our 2016-2017 program year. We wish to act as partners with the health care community and parents to ensure preventative health care for children and their families. We appreciate your assistance is completing this form so that parents may return it to our program.

Patient Information

Child's Name _____ Date of birth _____ Parent's/guardian's Name _____ Phone Number _____

Date of exam _____ Results _____ This practice is the child's dental home: ___ yes ___ no

Current Oral Health Status

Does the child have any teeth with untreated decay? ____ Yes (decay) ____ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ____ yes ____ no

Are there treatment needs? ____ Yes, urgent ____ Yes, not urgent ____ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventative Services
Examination __ yes __ no
X-rays __ yes __ no
Risk Assessment __ yes __ no
Cleaning __ yes __ no
Fluoride varnish __ yes __ no
Dental sealants __ yes __ no

Counseling/Anticipatory Guidance
__ yes __ no

Referral to Specialty Care
__ yes __ no
_____ (Please specify specialist)

Restorative/Emergency Care
Fillings __ yes __ no
Crowns __ yes __ no
Extractions __ yes __ no
Emergency Care __ yes __ no
Other: _____ (Please specify)

Future Oral Health Care Services

All treatment completed ___ yes ___ no Next recall date _____ / _____ (month/year)

More appointment needed for treatment? ___ yes ___ no

If yes, approx. number of appointments needed: ___ Next appointment date: _____ Time: ____

Oral Health Provider's Contact Information and Signature

Provider name (please print) _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date _____

411 South Prieur St. New Orleans, LA 70112 PHONE: 504-556-7522 FAX: 504-556-7501