LSU Health NEW ORLEANS
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 program. 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

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

## 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 EMAIL: lsuehs@lsuhsc.edu**