EASTCONN Where Learning Comes to Life
EARLY HEAD START

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Dental Health Report

Child's Name: ______________________________________ **DOB:** ______________________

Dental Provider:

Will this dental office or clinic be able to act as this child's dental home*? ☐ Yes ☐ No

***Definition:** A dental home is a source of oral health care that is comprehensive and continuously accessible that includes treatment, referral and co-ordination with dental specialists when appropriate.

Dental Examination:

______________ **Date of Dental Examination**
☐ Dental cavities or problems present that need treatment OR
☐ No dental problems noted

______________ **Date of Preventive services** (cleaning, sealant and/or fluoride application)

______________ **Date of Dental treatment visits** (restoration, fillings, extractions, etc.)

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Future care needed:

☐ Additional treatment appointments needed:

Approximate number of appointments needed: ________________

Date and time of next appointment: ____________________

Child has or needs the following:

☐ Home emphasis on oral hygiene and healthy habits
☐ Developmental concerns
☐ Dietary concerns
☐ Fluoride supplements

Dental Provider Signature and Contact Information:

______________________________________ ______________________________________
Provider's Name (printed) Provider's Signature

______________________________________ ______________________________________
Address Phone Number

Date: ________________________