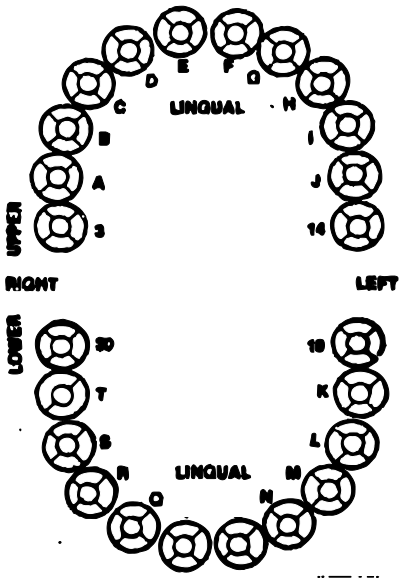
HEAD START OF GREATER DALLAS
DENTAL HEALTH RECORD

(HC-8)

Child Name:_____ DOB_____ Gender_____ Center_____
Address_____ Allergies_____

1. Source of payment for services:
   a. ☐ Medicaid
   b. ☐ CHIP
   c. ☐ Private Ins._____
   d. ☐ In-Kind Provider
   e. ☐ Parents/Guardians
   f. ☐ Head Start
   g. ☐ Other_____

2. Categorization/Priority
   a. ☐ **A**. Child needs attention Immediately
   b. ☐ **B**. Child needs attention soon.
   c. ☐ **C.** Child needs routine care
   d. ☐ **D.** Other_____



Tooth Num.	Surfaces	Description of Work	Treatment Approved	Date Service Performed	A.D.A. Code	Actual Charges	

4. YOUR CHILD HAS RECEIVED THE FOLLOWING: **(DATE)**_____

- ☐ CLEANING PROPHYLAXIS
- ☐ VISUAL ORAL CANCER CHECK
- ☐ X-RAYS
- ☐ SEALANTS
- ☐ TREATMENT (Restoration, Pulp therapy, extraction)
- ☐ FLUORIDE VARNISH
- ☐ ORAL HYGIENE INSTRUCTIONS
- ☐ FLUORIDE
- ☐ OTHER_____

6. RECOMMENDATIONS:
- ☐ X-Ray to Determine Treatment
- ☐ Treatment for Cavities/Decalcification/Fillings, Etc
- ☐ Sealants, Fluoride, Cleaning (Circle one)
- ☐ Nutritional Counseling
- ☐ Brush &Floss 2X daily/Brush @ Gum line
- ☐ Treatment (Pulp Therapy, Extraction, Orthodontic Referral)
- ☐ Mixed Dentition/Attrition/Fractured/etc.

Explain_____

7. Approximate Number of visits_____

Next Appointment:_____

Approximate Cost of Service $_____

Approximate In-kind Earned $_____

8. All planned treatment/ services (___ is, ___ is not) complete.

_____ _____ _____
Dentist Name (Please Print) Signature Date

_____ _____
Address, City, State & Zip Code Phone