SITE:_____
CLASS:_____ **AM PM**

ORAL HEALTH ASSESSMENT

Community Action Head Start
2475 Center St. NE
Salem, OR 97301
Phone: 503 -581-1152
Fax: 503-581-3012

Child's Name: _____

Date of Birth: _____

Exam Date: _____

Clinic Name: _____ Phone #: _____

Dentist Name: _____ Fax #: _____

☐ **No Treatment Needed (Child is up to date with care)**

☐ **Restorative Treatment Needed**
Approximate number of appointments needed: _____

☐ **Restorative Treatment in Progress**
Has treatment begun? Yes / No Date: _____

Next scheduled appointment: _____

☐ **Treatment Complete**
Date Treatment Completed: _____

Did child receive preventive care (Fluoride varnish or cleaning)?

☐ **Yes** ☐ **No**

Child approved for Fluoride:

☐ **Yes** ☐ **No**

Applied _____ Applied _____
Applied _____ Applied _____

ASTDD/Basic Screening Survey Indicators:

Child has cavities: ☐ Yes ☐ No

Child has ECC: ☐ Yes ☐ No

Child has treated decay (fillings): ☐ Yes ☐ No

Treatment Urgency:

☐ **0** No obvious problems

☐ **1** Early Dental Care needed

☐ **2** Urgent Care needed (pain/infection)

Comments:

Signature of Dentist: _____ **Date:** _____/_____/_____