NAVAJO HEAD START
DENTAL EXAMINATION & TREATMENT

Child's Name: ______________________ Sex: M ☐ F ☐ Date of Birth: __________

Parents(s) / Guardian: ______________________ Chart #: __________

Center / Home Base: ______________________ Dental Provider: __________

I. MEDICAL HEALTH HISTORY: To be completed at interview with parent / guardian

1. Child is reported to have: (√) all that applies

☐ Allergies ☐ Liver Disorder
☐ Asthma ☐ Rheumatic Fever
☐ Bleeding ☐ Sickle Cell Disease
☐ Diabetes ☐ Heart Murmur
☐ Epilepsy ☐ Other

2. If child under a physician's care? ☐ Yes ☐ No
   Physician's Name: __________
3. Is child now receiving medication? ☐ Yes ☐ No
   Type of allergies: __________
4. Is child now receiving:
   Tropical Fluoride Application? ☐ Yes ☐ No
   Fluoridated Water? ☐ Yes ☐ No ☐ Unknown
   ☐ NTUA ☐ Private Well ☐ City
5. Does child need further treatment? ☐ Yes ☐ No

5. Has child previously seen a dentist? ☐ Yes ☐ No
   Dentist's name: __________
   Date of last visit: __________

II. EXAMINATION / TREATMENT: To be completed by Dentist

A.

Date	Dental Hygiene	ECC			# Filling	# Extraction(s)	Pulp Therapy
		None	Mild	Severe			

Remarks: __________

Signature of Examiner / Date: __________

B.

Date	# Filling	Extractions	Pulp Therapy	Sealents	SSC

III. Is Child Planned Treatment Completed? ☐ Yes ☐ No
If not, explain: __________

IV. Recommendation for On-going Dental Care: __________
Referral to Specialist: __________

V. I certify that I have completed the above service(s).

Dentist Signature: __________ Date: __________

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