# Head Start Oral Health Form—Pregnant Women

## Patient Information

- **Patient’s name**
- **Date of birth**
- **Phone number**
- **Address**
- **City**
- **State**
- **Zip code**

This practice is the patient’s dental home:  ○ Yes  ○ No

## Current Oral Health Status

- Does the patient have any teeth with untreated decay?  ○ Yes (decay)  □ No (decay free)
- Does the patient have any teeth that have previously been treated for decay, including fillings, crowns, or extractions?  ○ Yes  □ No
- Does the patient have gum disease?  □ Yes  □ No
- Are there treatment needs?  □ Yes, urgent  □ Yes, not urgent  □ No treatment needs

## Oral Health Care Services Delivered During Visit

### Diagnostic/Preventive 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

(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 appointments needed for treatment?  □ Yes  □ No

If yes: Approximate number of appointments needed: _____  Next appointment: Date: ________  Time: ________

## Additional Information for Patient, Head Start Staff, and Medical Providers

## Oral Health Provider’s Contact Information and Signature

- Provider name *(please print)*
- Phone number
- Fax number
- Practice name
- Address
- Provider signature
- Date of service

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