TMC
Migrant and Seasonal Head Start

Child Oral Health Assessment

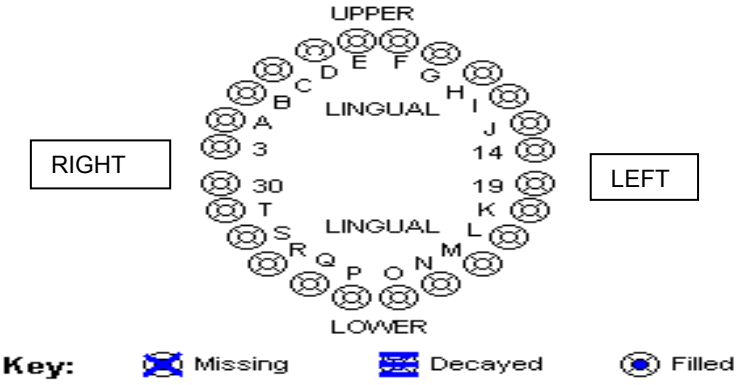
Child's Name: _____ DOB_____ Center: _____

Date Seen: ____/____/_____

Provider Setting: ☐ Doctor/Clinic ☐ Center ☐ Other: Specify _____

Type: ☐ Examination ☐Screening ☐Treatment

ORAL CONDITION



Number of times per day child brushes teeth: |___|___|
Flossing Frequency ☐NA ☐Never ☐Daily ☐Weekly ☐Occasionally

Gum Condition:
☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

Dental Needs:

Preventive Services	**☐Medical**	**☐No Needs**
☐ Fluoride Supplement	☐ Treatment	☐ Cleaning
☐ Oral Hygiene Instruction		
☐ Sealants		
☐ Other: Specify _____		

DENTAL SERVICE PROVIDED AT TIME OF VISIT:

☐ TREATMENT (restoration, pulp therapy, extraction) ☐ CLEANING ☐ FLUORIDE ☐SEALANTS ☐OTHER
☐NO PROBLEMS

All treatment is completed at this time. ____Yes _____No Follow-up Date: _____

General Comments: _____
_____
_____

Provider Signature: _____ **Date:** _____

Print Provider Name: _____