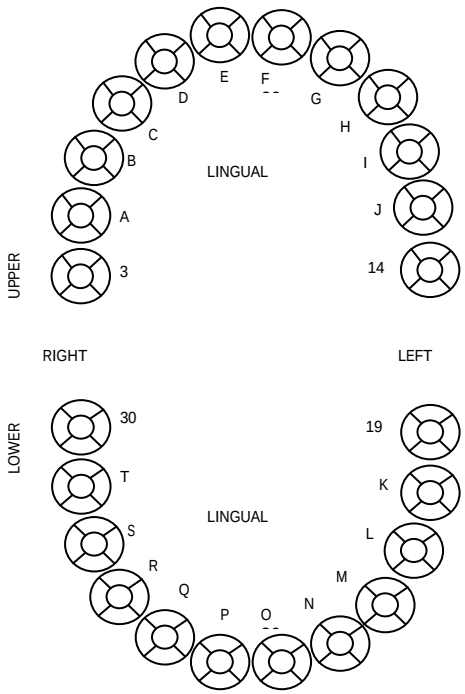
JEFFERSON COUNTY HEAD START

Serving Jefferson, Clear Creek, Gilpin, and Park counties

DENTAL HEALTH EVALUATION

CHILD'S NAME:	BIRTHDATE:	CENTER/CLASS:

Date of Exam: _____ **Routine Exam □** **Follow Up Treatment □** **Primary Dental Home □ YES □ NO**



Preventative care Received today: **Comments:**
□ Cleaning
□ Fluoride Application
□ Sealants

Oral Health Status: **Comments:**
□ No Oral health disease
□ Active oral health disease
□ Cavities (#_____)

Treatment Received Today: **Comments:**
□ Restoration(#_____)
□ Extraction (#_____)
□ All restorative treatment completed

Treatment Needed at Next Visit:
□ No treatment needed, recall in 6 months
□ Preventative Care (ex. Sealants)
□ Restoration
□ Extraction

Approximate number of visits needed: (#_____)
Date of next appointment: _____

Referrals:
□ Needs referral to pediatric dentist
□ Needs treatment under general anesthesia
□ Needs referral to other dental specialist
Referred to:
Name: _____Phone Number: _____Appointment Date: _____

Signature of Provider: _____ Printed Name: _____Date: _____

Address: _____ Phone: _____ Fax: _____

Return Fax: 720-497-7989 Return Email: ahsfax@co.jefferson.co.us