Dental Exam

Holy Cross Head Start Inc.

150 Maryland Street
Buffalo, New York 14201
Telephone: (716) 852-8373 Fax: (716) 854-7046

Child Oral Health Assessment

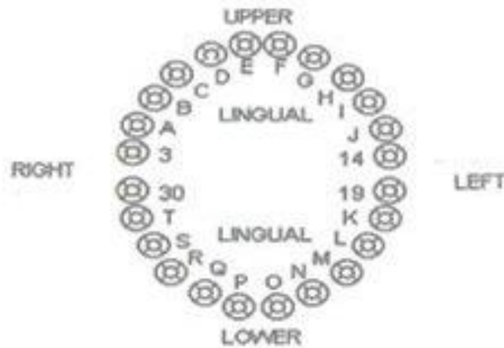
Name: ______________________________ DOB ____________________

Completed by: ________________________ (Agency name)

Dentist/Clinic Name: ____________________

Exam Date ________________

Screening Date ______________



Key: Missing Decayed Filled

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

Preventative Care Received:
☐ Fluoride ☐ Cleaning ☐ Sealant ☐ Other

Dental Needs:
☐ No Needs

Needs treatment: ☐
☐ Fillings ☐ Caps/Crown ☐ Pulp Therapy ☐ Restoration ☐ Extraction
☐ Surgery ☐ Other____________________

Treatment Received ☐
☐ Fillings ☐ Caps/Crown ☐ Pulp Therapy ☐ Restoration ☐ Extraction
☐ Surgery ☐ Other____________________

Comments: ____

Next Appointment Date____________________ Time______________

Dentist Signature: ______________________________ **Date:** ____________

Print Dentist Name: ______________________________

Revised May 2020