

# Holy Cross Head Start Inc.

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## Child Oral Health Assessment

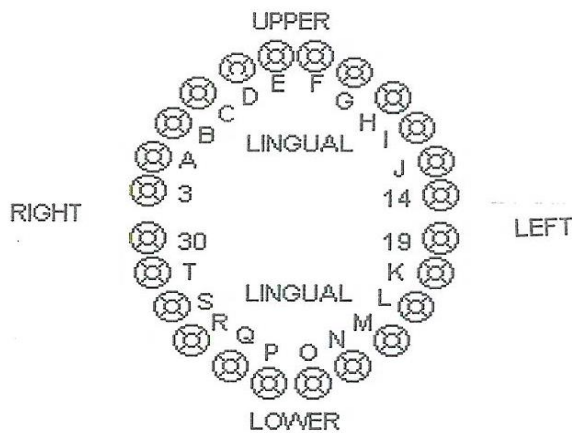
Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Completed by: \_\_\_\_\_ (Agency name)

Dentist/Clinic Name: \_\_\_\_\_

Exam 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: \_\_\_\_\_