Early Childhood Oral Health Form
McPherson/Marion County Early Childhood Programs
915 East 1st Street, McPherson KS 67460
Phone: 620-241-9590 Fax: 620-241-9565

Parent Information

Child's Name: Date of Birth:

Is this the child's dental home? Yes No

Current Oral Health Status

Does the child have any teeth with untreated decay? Yes (decay) No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or other extractions? Yes No

Are there treatment needs? Yes No

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?

☐ **Yes** ☐ **No**

Restorative/Emergency Care

Fillings:	**Yes**	**No**
Crowns:	**Yes**	**No**
Extractions:	**Yes**	**No**
Emergency Care:	**Yes**	**No**

Other: _____

Future Oral Health Care Services

All treatment completed? Yes No
More appointments needed for treatment? Yes No
If Yes, approximate number of appointments needed: _____
Next appointment: Date:_____Time: _____

Additional Information for Parents, Head Start staff, and Medical Providers

Oral Health Health Provider's Contact information and Signature

Provider's Name: (Print)	Phone Number:	Fax Number:

Practice Name: Address:

_____

Provider's Signature **Exam Date**