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		
Providers Name: (Print)	Phone Number:	Fax Number:
Practice Name:	Address:	

_____

Providers Signature **Exam Date**