TLINGIT & HAIDA HEAD START

Central Council Tlingit and Haida Indian Tribes of Alaska

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DENTAL EXAMINATION REPORT

CHILD'S NAME: _____ SEX: _____BIRTH DATE:__/__/__AGE: _____

PARENT(S) NAME: _____PHONE NUMBER: _____

HEAD START SITE: _____

Child is a regular patient at this office: ☐ Yes ☐ Episodic ☐ First visit with this office

Diagnostic and Preventive Procedures Performed:

☐ Clinical Examination ☐ Dental Cleaning ☐ Fluoride application ☐ X-Rays

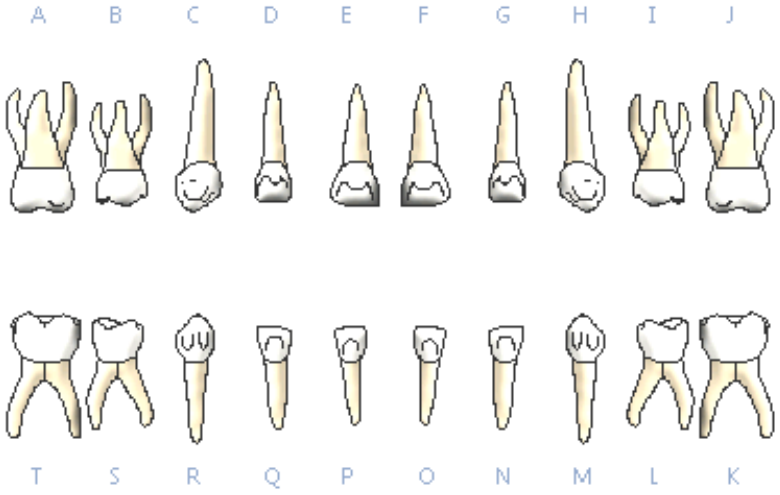
Caries Risk Status: ☐ High ☐ Moderate ☐ Low

Current Oral Health Status:

Cavities: _____ (how many)
Gums and supporting tissues: ☐ Healthy ☐ Mild Gingivitis ☐ Moderate Gingivitis ☐ Severe Gingivitis
Other Findings: _____

Recommendations:

☐ No further treatment needed at this time. Return to clinic in _____ months for an examination.
☐ Additional treatment is required.



_____ _____ _____
Dentist Name (Please Print) Signature Date

_____ _____
Clinic Name, Address, City Phone Number