TLINGIT & HAIDA HEAD START

Central Council Tlingit and Haida Indian Tribes of Alaska

Mailing: 9097 Glacier Hwy, Juneau, AK 99801·Physical 9095 Glacier Highway • Juneau AK 99801
Phone 907.463.7127 • Toll Free 800.344.1432 • Fax 1.877.389.7796 • www.ccthita-nsn.gov

DENTAL EXAMINATION REPORT

(Head Start requires complete annual dental/oral health exam documentation as necessary in order to provide prompt assistance to families to best meet the oral health care needs of the child. Please complete all boxes, sign, date and provide a copy to parent/guardian and **FAX a copy to Tlingit & Haida Head Start at 1.877.389.7796).**

Child's name:_____Sex: ____ Birth date: ___/___/___Age: _____

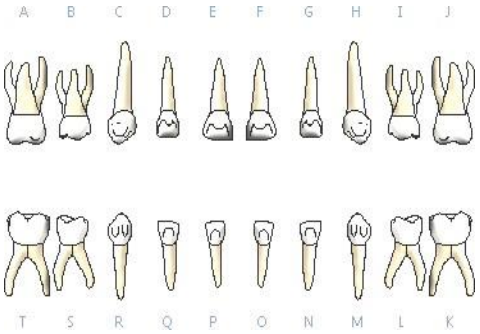
Parent/Guardian name: _____ Telephone/Cell number: _____

Head Start Site/Community: _____

Child is a regular patient at this office (dental home): □ Yes □ No □ Episodic □ First visit with this office

Diagnostic and Preventive Procedures Performed:
□ Clinical Examination □ Cleaning □ Fluoride □ Sealants □ X-Rays

Current Oral Health Status:
Caries Risk Status: □ High □ Moderate □ Low **Cavities:** _____(how many)
Gums and supporting tissues: □ Healthy □ Mild Gingivitis □ Moderate Gingivitis □ Severe Gingivitis
Other Findings: _____

Recommendations:	**Restorative/Emergency Care:**
□ No further treatment needed at this time. □ Additional treatment is required. □ Return to clinic in____months for an exam. **Anticipatory Guidance:** □ Diet (sugary drinks) □ Teeth brushing □ Flossing □ Other:_____	 □ Fillings_____ □ Crowns_____ □ Extractions _____ □ Emergency care _____ □ Other _____
Referral to Specialty Care: □ Yes □ No *(Please Specify Specialty)*	

_____ _____ _____
Dentist name (Please Print) Signature Exam Date

_____ _____
Clinic Name, Address, City Telephone Number

_____ _____
Parent/Legal Guardian Signature Authorizing Release **Date**: