COLLEGE OF SOUTHERN IDAHO HEAD START/EARLY HEAD START
998 Washington St. N.
PO Box 1238
Twin Falls, Idaho 83303-1238
208-736-0741

Child Dental Exam

Appointment Date: ___/___/____ **Child's Name:** _____**EHS Center: J/ R/ TF Center:**_____

Exam Completed By: ☐ Dentist ☐ Pediatrician

Provider Setting: ☐ Doctor/Dentist/Clinic ☐ School/Center ☐ Other: Specify _____

Flossing Frequency: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of Times Per Day Child Brushes Teeth: |__|__|

Uses Fluoride Toothpaste: ☐ Yes ☐ No **Takes Fluoride Supplement:** ☐ Yes ☐ No

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

General Comments on Oral Condition:

Today's Visit:

Visual Screening
Full Exam
X-Rays
Cleaning
Fluoride Treatment
Oral Hygiene Instruction
Treatment (specify)
_____
_____
_____
_____
_____
_____
_____

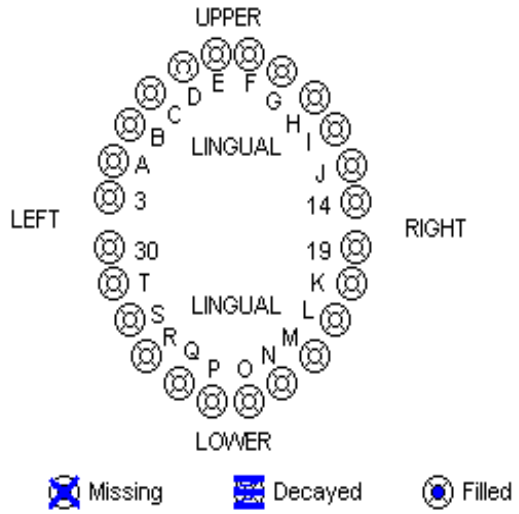
Treatment:

No Treatment Needed
Needs cleaning

Needs oral hygiene instruction
Treatment Needed

Next Appointment Date:
_____/_____/_____

Treatment Plan:
_____
_____
_____
_____
_____



Provider Signature: _____**Completion Date:** ____/____/_____

Printed Name of Provider: _____

Address: _____ **Phone:** _____