Miami-Dade County
Community Action and Human Services Department
Head Start/Early Head Start Division

MIAMI-DADE COUNTY

Dental/Oral Health Exam Record

CHILD'S NAME: ______________________ BIRTH DATE: __________

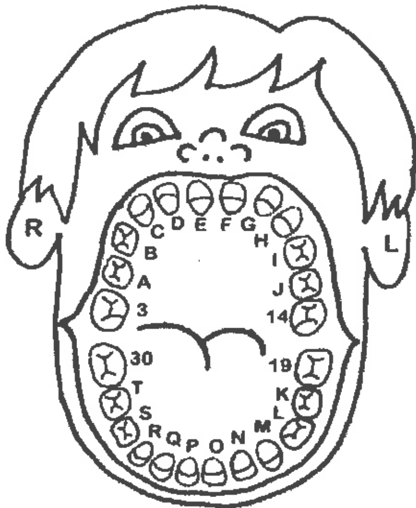
HEAD START/EARLY HEAD START CENTER: ______________________ CLASSROOM: __________

HISTORY: ______________________

ALLERGIES: ______________________

Please complete the following information for the Head Start/Early Head Start Program. (Mark an "X" next to ALL boxes that apply.)

DENTAL PROVIDER	SERVICES COMPLETED:	EXAM & TREATMENT SERVICES:	TREATMENT INDICATED:
	☐ Oral Hygiene Instruction	☐ Normal/Healthy Exam	☐ All Treatment Completed
	☐ Topical Fluoride & Prophy	☐ Treatment In Progress	☐ No. of Additional Visits Needed: ______
	☐ Sealants Applied		☐ Referred to: ______
	☐ Systemic Fluoride Prescribed		☐ Return to Clinic: ______



FINDINGS:

3		19	
A		K	
B		L	
C		M	
D		N	
E		O	
F		P	
G		Q	
H		R	
I		S	
J		T	
14		30	

Abscess (A)	Decalcification (DEC)	Caries (C)
Fracture (FR)	Extraction (EXT)	Missing (I)
Mesial – M	Distal – D	Facial – F
Lingual – L	Occlusal - O	

I certify that I have completed the services indicated above and that the itemized charges do not exceed my usual and customary fees.

PROVIDER STAMP HERE: ______

Examined By (Print Name) ______ Signature ______ Date ______

Parent/Legal Guardian Signature ______ Date ______