2545 North 29th St
Milwaukee, WI 53210
414-562-2929 ext. 234
414-918-2733 fax

Head Start Dental Exam Form

Date: _____ Head Start Campus: Next Door-_____

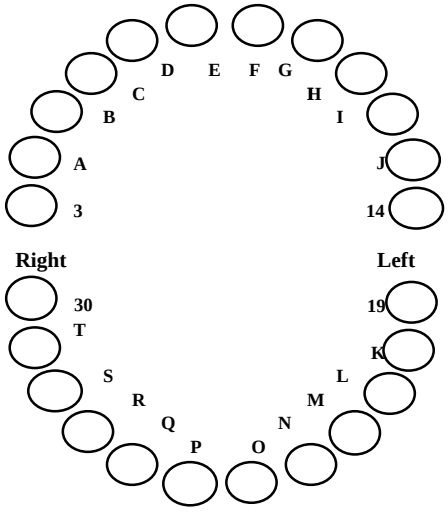
Patient Name: _____ DOB: _____

	WNL
Lymph Nodes	
Pharynx	
Tonsils	
Soft Palate	
Hard Palate	
Floor of Mouth	
Lips	
Skin	
TMJ	
Tongue	
Vestibules	
Buccal Mucosa	

Missing

Decayed

Filled



Services completed today:

Exam ☐
Prophylaxis ☐
Fluoride Varnish ☐

Notes:

IS DENTAL CARE COMPLETE? ☐ **Yes** ☐ **No**

IS DENTAL CARE IN PROCESS? ☐ **Yes** ☐ **No**

Child needs follow up for: **Next Appointment:** _____

Untreated decay ☐

Urgent care (pain, infection or swelling) ☐

Fluoride therapy up to four times in 1-year ☐

Refer Child to pediatric dentist ☐

Comments/Special Considerations: ***For Staff/Dentist only*:**

_____

_____

Signature of examining Dentist: _____ **Date of Exam:** _____

Print name of DDS:_____

Dental Clinic Name & Phone Number: _____