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: ____________

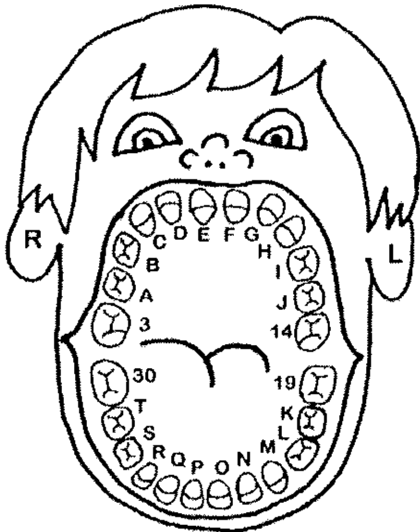
HISTORY: ______________________

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:



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

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

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