Five Sandoval Indian Pueblos, Inc. Head Start Program

ORAL HEALTH ASSESSMENT/DENTAL EXAM

Name of Clinic: **Address:** **Phone Number:**	Child's Name: Date of Birth:

The remainder of this form is to be completed and signed by a licensed Dental Professional (Dentist).

DENTAL SERVICES PROVIDED

Exam _____ Fluoride _____ Prophy _____ X Rays _____ Sealants _____

Treatment (restoration, pulp therapy, extraction, etc.) _____

Approximate number of visits to complete treatment: _____

Other ____

DATE OF NEXT ROUTINE EXAM: ______________________________

DENTAL SERVICES NEEDED

Exam _____ Fluoride _____ Prophy _____ X Rays _____ Sealants _____ Other _____

Treatment (restoration, pulp therapy, extraction, etc.) _____ Referral _____
Approximate number of visits to complete treatment: _____
Dates of Scheduled Treatments:

____

SUMMARY OF DENTAL SERVICES

_____ All planned treatment is COMPLETE _____ Treatment was Referred

_____ All planned treatment is NOT COMPLETE _____ No treatment needed at this time

Additional notes/comments:

Print Name of Dentist: ______________________________________

Signature of Dentist: ______________________________________ Date: ____________

FIVE SANDOVAL INDIAN PUEBLOS, INC.
JEMEZ-COCHITI-SANTA ANA-SANDIA-ZIA

PLEASE RETURN EXAM RECORD TO: FSIP, Inc. Head Start
4321-B Fulcrum Way NE, Rio Rancho, NM 87144
Attention: Yvette Aguilar or LaVonne Cate
PHONE 505-867-3351 FAX 505-867-3514