ORAL HEALTH ASSESSMENT/DENTAL EXAM

Umatilla Morrow Head Start
110 NE 4th St
Hermiston, OR 97838
Phone: (541) 564-6878 Fax: (541) 564-6879

_____ **Child's Name** _____ **Date of Birth** _____ **Site**	OHP # _____ DCO _____ Private_____ None _____

Date of Last Exam _____

No Treatment Needed (Child is up to date with care) ☐

Treatment Indicated ☐ **Approximate number of appointments needed**_____

Treatment in Progress ☐ **Next scheduled appointment**_____

Child approved for fluoride Yes No Applied_____ Applied_____ Applied_____	**Did Child receive preventive care (Fluoride varnish or cleaning)?** ☐ **Yes**_____ ☐ **No**_____

ASTDD/Basic Screening Survey indicators:

Child has cavities: ☐ Yes ☐ No

Child has treated decay (fillings) ☐ Yes ☐ No

Child has ECC (current or past decay in upper anterior teeth): ☐ Yes ☐ No

Treatment Urgency:

☐ 0 No obvious problems
☐ 1 Early Dental Care needed
☐ 2 Urgent Care needed (pain/infection)

Notes:

Treatment ☐ complete ☐ incomplete

Name of Dentist/Clinic _____ **Phone:** _____

Signature of Dentist: _____ **Date:** _____/_____/_____

PLEASE RETURN EXAM RECORD TO UMCHS AT 110 NE 4th STREET, HERMISTON, OR 97838
(541) 564-6878 – (541) 564-6879 FAX