2024-2025

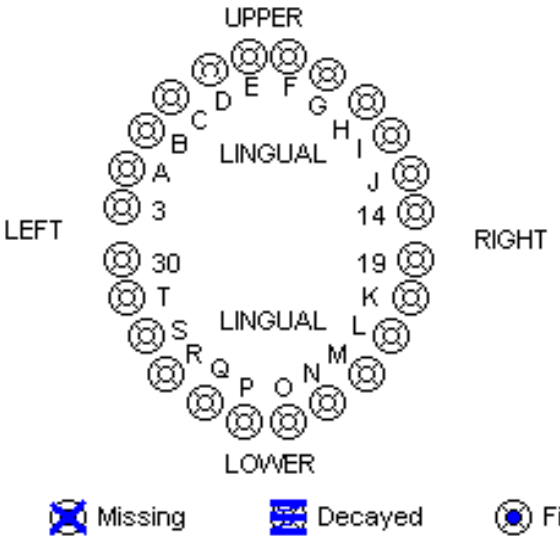
Community Services for Children, Inc.
Head Start / Early Head Start of the Lehigh Valley / Pre-K Counts
1520 Hanover Avenue, Allentown, PA 18109
610-437-6000 • Fax: 610-820-6841• Email: healthdocuments@cscinc.org

Child Oral Health Assessment

Date of Exam: ____/____/_____ **Child's Name:** _____D.O.B. _____

Assessment Type: ☐ Exam

Provider Setting: ☐ Dentist/Clinic ☐ School/Center



Key: Missing Decayed Filled

Flossing Frequency:
☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of Times Per Day Child Brushes Teeth: _____

Gum Condition:
☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

Dental Services Provided:
☐ Fluoride
☐ Cleaning
☐ Oral Hygiene Instruction
☐ No Further Treatment Needed

Treatment Needed
☐ Treatment _____☐ Cleaning ☐ Fluoride Supplement☐ Oral Hygiene Instruction ☐ Other _____

☐ Appointment Date for Treatment to be completed _____

Treatment Received
☐ Received Treatment Date_____
☐ Fluoride Supplement ☐ Pulp Therapy ☐ Cleaning ☐ Extraction ☐ Restoration ☐ Oral Hygiene Instruction
☐ Other (Please explain) _____

Provider Signature: _____ **Date:** _____

Print Dental Practice Name: _____ **Phone:** _____