ORAL HEALTH ASSESSMENT

Portland Public Schools Head Start
4800 NE 74th Ave, Portland OR 97218
Phone: 503-916-5724, Fax: 503-916-2714

______________________________ **Child's Name**	OHP # ____________
______________________________ **Date of Birth** **Zip Code**	DCO ____________
______________________________ **Site** **Classroom**	Private____________
	None ____________

No Treatment Needed (Child is up to date with care) ☐ **Date of assessment** ____________

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

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

Did child receive preventive care?

☐ Fluoride varnish ☐ Cleaning ☐ Other ____________

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)
ASTDD/Basic Screening Survey indicators: **Pregnant Women** Pregnant woman has cavities: ☐Yes ☐No Pregnant woman has treated decay (fillings) ☐Yes ☐No Pregnant woman has gum disease: ☐Yes ☐No	Treatment Urgency: 0 ☐ No obvious problems 1 ☐ Early Dental Care needed 2 ☐ Urgent Care needed (pain/infection)

Notes/Comments:

Treatment ☐complete ☐incomplete

Name of Dentist/Clinic ______________________ **Phone:** ____________

Signature of Dental Provider: ______________________ **Date:** ____/____/____