[_____]
Patient
[_____]
ID

KIDS' SMILES

Oral Health Screening, Fluoride Varnish Application, Education and Referral Program

Personal Record (as part of health record)

Child's Name:_____ **Birthdate**:_____
Parent's Name:_____ **Age**:_____
Address:_____

I understand that my child will be screened by _____ (Health Department Nurse), fluoride varnish will be applied to my child's teeth, educational materials, and a referral made to a local dentist if necessary. I understand that for the most benefit, this program should be repeated every six months throughout their childhood. I understand that my child's teeth may retain the feel of the varnish for two or three days but will return to the original condition. If my child has Medicaid benefits, I understand that there will be no charge to me or my family for this service. If my child doesn't have Medicaid, there may (or may not) be a nominal fee for this service.

SIGNED:_____ **Date:**_____
Parent/Guardian

First Visit: Significant Med Hx? Y N Describe:_____
Any Dental Hx? Y N Describe:_____
Screening: Decay in baby teeth? Y N No. of teeth decayed? ___ White spots? Y N
Total No. teeth present?___ Other oral findings? Y N
Describe:_____
Fluoride varnish applied? Y N If not why not?_____
Education: Materials given to parent? Y N Parent counseled? Y N
Referral to local dentist? Y N Name of dentist:_____
SIGNATURE/Degree of Provider:_____ **Date:**_____

Second Visit: Missed appointment Y N Comments:_____
Change in Med Hx? Y N Describe:_____
Change in Dental Hx? Y N Describe:_____
Screening: Decay in baby teeth? Y N No. of teeth decayed? ___ White spots? Y N
Total No. teeth present?___ Other oral findings? Y N
Describe:_____
Fluoride varnish applied? Y N If not why not?_____
Education: Materials given to parent? Y N Parent counseled? Y N
Referral to local dentist? Y N Name of dentist:_____
SIGNATURE/Degree of Provider:_____ **Date:**_____

[______________] Patient
[______________] ID

KIDS' SMILES (continuation)

Oral Health Screening, Fluoride Varnish Application, Education and Referral Program

Personal Record (as part of health record)

Visit Number _____: Change in Med Hx? Y N Describe:________________________
Change in Dental Hx? Y N Describe:_______________________
Screening: Decay in baby teeth? Y N No. of teeth decayed? ___ White spots? Y N
Total No. teeth present?___ Other oral findings? Y N
Describe:____
Fluoride varnish applied? Y N If not why not?________________________________
Education: Materials given to parent? Y N Parent counseled? Y N
Referral to local dentist? Y N Name of dentist:________________________________
SIGNATURE/Degree of Provider:_______________________________ Date:______

Visit Number _____: Change in Med Hx? Y N Describe:________________________
Change in Dental Hx? Y N Describe:_______________________
Screening: Decay in baby teeth? Y N No. of teeth decayed? ___ White spots? Y N
Total No. teeth present?___ Other oral findings? Y N
Describe:____
Fluoride varnish applied? Y N If not why not?________________________________
Education: Materials given to parent? Y N Parent counseled? Y N
Referral to local dentist? Y N Name of dentist:________________________________
SIGNATURE/Degree of Provider:_______________________________ Date:______

Visit Number _____: Change in Med Hx? Y N Describe:________________________
Change in Dental Hx? Y N Describe:_______________________
Screening: Decay in baby teeth? Y N No. of teeth decayed? ___ White spots? Y N
Total No. teeth present?___ Other oral findings? Y N
Describe:____
Fluoride varnish applied? Y N If not why not?________________________________
Education: Materials given to parent? Y N Parent counseled? Y N
Referral to local dentist? Y N Name of dentist:________________________________
SIGNATURE/Degree of Provider:_______________________________ Date:______

Visit Number _____: Change in Med Hx? Y N Describe:________________________
Change in Dental Hx? Y N Describe:_______________________
Screening: Decay in baby teeth? Y N No. of teeth decayed? ___ White spots? Y N
Total No. teeth present?___ Other oral findings? Y N
Describe:____
Fluoride varnish applied? Y N If not why not?________________________________
Education: Materials given to parent? Y N Parent counseled? Y N
Referral to local dentist? Y N Name of dentist:________________________________
SIGNATURE/Degree of Provider:_______________________________ Date:______