

(_____)
Patient
(_____)
in

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:** _____

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:** _____