Mid America Head Start

HEAD START PROGRAM

Delegate / Partner: Center Early Childhood

Dental Examination Report

HEAD START SITE: _____ DATE of Exam: ___/___/___

CHILD'S NAME: _____ SEX: ____ BIRTH DATE: ___/___/___ AGE: _____

PARENT(S) NAME: _____ PHONE NUMBER: _____

INSURANCE NUMBER (MEDICAID OR PRIVATE INSURANCE): _____

FAMILY ADVOCATE _____ OFFICE NUMBER _____ FAX _____

Diagnostic and Preventive Procedures Performed:

- ☐ Clinical Examination
- ☐ X-Rays
- ☐ Prophylaxis
- ☐ Fluoride application
- ☐ **Other** _____

Current Status:

Cavities: _____ **(How Many)** **Recurrent decay around old fillings:** _____ **(How Many)**

Gums and supporting tissues:

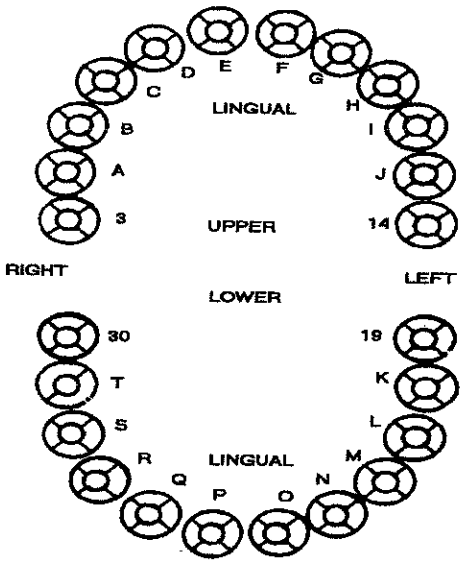
- ☐ Normal & Healthy
- ☐ Slight Inflammation (gingivitis)
- ☐ Moderate Inflammation (gingivitis)
- ☐ Advanced disease (periodontitis)

Other: _____

Recommendation:

- ☐ No further treatment recommended at this time. Return in _____ months for an examination.
- ☐ Additional dental treatment is required. Treatment plan is identified below.

Patient scheduled to return for treatment on _____
Date



Tooth # or letter	Description of Dental Services Required

☐ **All treatment has been completed as of** _____
Date

_____ _____ _____
Dentist Name (Please Print) Signature Date

_____ _____
Address, City, State & Zip Code Phone No.

Form 1085

S. Reece 03/14