MAHS: HEAD START PROGRAM
Center School District: Center ECC
8817 Wornall Road Kansas City, MO 64114

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)**

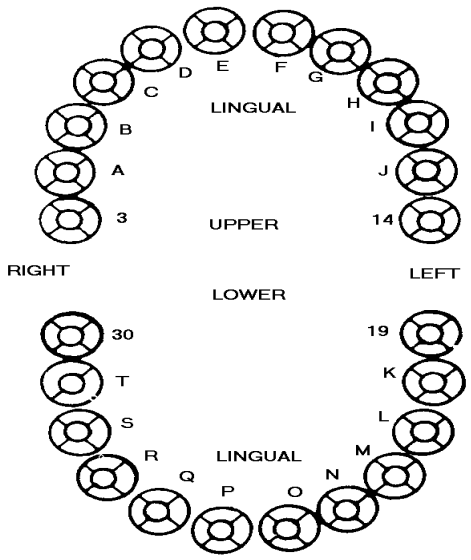
Gums and supporting tissues:
- ❑ Normal & Healthy
- ❑ Slight Inflammation (gingivitis)
- ❑ Moderate Inflammation (gingivitis)
- ❑ Advanced disease (periodontitis)

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.