

HEAD START PREGNANT WOMAN DENTAL EXAMINATION

Patient's Name: _____

Birth Date: _____

Phone #: _____

Address: _____

SERVICES PROVIDED: (PLEASE RECORD EACH TREATMENT ON SEPARATE LINE)

MONTH	DAY	YEAR	TOOTH	DESCRIPTION OF WORK

TREATMENT CODE: SURFACES: M=MESIAL, D=DISTAL, O=OCCLUSAL, L=LINGUAL, I=INCISAL, H=BUCCAL OR LABIAL
 MATERIALS: A=AMALGAM, S=SILICATE, P=ACRYLIC, C=STEEL CROWN, O=OTHER

IMPORTANT: ___ CHECK HERE IF ALL WORK IS COMPLETED
 ___ CHECK HERE IF ADDITIONAL WORK IS REQUIRED
 ___ CHECK HERE IF TREATMENT HAS BEEN DISCONTINUED; EXPLAIN ABOVE

CONCERNS, PLANS, FOLLOW-UP:

NEXT APPOINTMENT IS SCHEDULED ON:

_____ (DATE) _____ (TIME)

I, _____, authorize provider listed below to release this form to Garrett-Keyser-Butler Head Start via mail, fax or in person.

 (Patient's Signature)

 (Date)

I CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

 (DENTIST'S NAME - (PLEASE PRINT) (260) _____ - (PHONE #) _____ (DATE)

 (DENTIST'S SIGNATURE)

PLEASE RETURN FORM TO GKB HEAD START - 504 SOUTH SECOND ST. - GARRETT, IN 46738 or FAX to 260-357-3044.