

# HEAD START DENTAL EXAMINATION

**I. Child Information (Completed by Head Start Staff)**

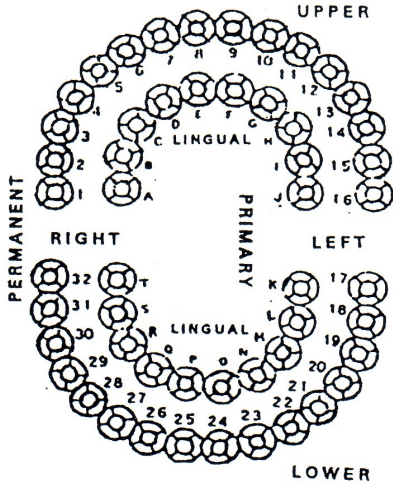
Child's Name: \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Parent's Name: \_\_\_\_\_ Home Address: \_\_\_\_\_  
 Head Start Center: GKB Head Start Class: \_\_\_\_\_  
 Source of Payment:  HHW # \_\_\_\_\_  Head Start  Other: \_\_\_\_\_ Group # \_\_\_\_\_  
 Medical Alert: \_\_\_\_\_

**II. Exam (Completed by Dentist)**

Name of Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Date of Examination: \_\_\_\_\_ Fax #: \_\_\_\_\_

**A. Existing Conditions**

Red = Decay Blue = Filling X = Missing


**B. Proposed Treatment (Indicate the approximate number of visits if possible)**

\_\_\_\_\_ Fillings                      Number of  
 \_\_\_\_\_ Crowns                      Appointments \_\_\_\_\_  
 \_\_\_\_\_ Pulp Treatments  
 \_\_\_\_\_ Extractions                      Approximate Cost \_\_\_\_\_  
 \_\_\_\_\_ Other \_\_\_\_\_

**PLEASE CHECK SERVICES PROVIDED AT TODAY'S APPOINTMENT**

Fluoride     Prophylaxis     Oral Hygiene Instruction  
 Any additional services provided or comments: \_\_\_\_\_  
 \_\_\_\_\_  
 NEXT APPOINTMENT IS SCHEDULED ON: \_\_\_\_\_ (Date) \_\_\_\_\_ (Time)

**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

I, \_\_\_\_\_, parent/guardian of above minor child, authorize provider listed below to release this form to Garrett-Keyser-Butler Head Start via mail, fax or in person.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

**I CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED**

\_\_\_\_\_  
(DENTIST'S SIGNATURE)

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