

**Hoosier Uplands Children's Services
Head Start/Early Head Start Dental Exam/Treatment Record**

I. Child Information (Completed by Parent or Head Start/EHS Staff)

Child's Name _____ Sex ____ Birthdate _____
 Source of Payment: Medicaid Private Insurance Other: _____

Medical Alert: _____

II. Exam (Completed by Dentist)

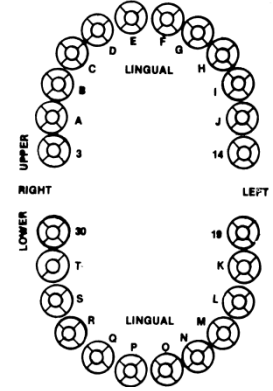
A. Dental Services on Initial Visit

Exam Prophy Fluoride X Rays

- This child **Passed** the initial dental exam and does not require treatment.
 This child **Failed** the initial dental exam and requires the treatment below:

B. Proposed Treatment (Indicate approximate # needed)

_____ Fillings
 _____ Crowns
 _____ Pulp Treatments # of Appointments _____
 _____ Extractions **Next Appointment** _____
 _____ Other _____



C. Risk Factors Identified

Harmful Oral Habits Dietary Concerns Developmental Issues No Fluoridated Water

Signature of Dentist _____ **Date of Exam** _____

III. Treatment (Completed by dentist as treatment progresses)

Date	Treatment	Fee	Date	Treatment	Fee

- All planned Treatment Is Complete Needs Fluoride Supplement
 Needs Further Treatment Needs Dental Hygiene Home Education
 Needs To Be Referred Needs Routine Recall Appointments

Comments: _____

Signature of Dentist _____ **Date** _____

IV. Final Report (Completed by dentist at final visit)

I certify that I have completed the above services and that the child has received all necessary treatment as requested by the Head Start/EHS Program.

Signature of Dentist _____ **Date** _____

Please fax to 812-849-0627 Attn: EHS/HS Health