Area Five Agency Head Start
DENTAL EXAM FORM
1801 Smith Street
Logansport, IN 46947
Phone (574)722-4451 Fax (574)722-3447

Child's Name: _____ Birth Date: ____/____/____ Source of Payment: _____

THE FOLLOWING TO BE COMPLETED BY EXAMINING DENTIST:

DENTAL EXAM INFORMATION

1. Dental exam date: ____/____/____ Overall oral health condition: □ excellent □ good □ fair □ poor
2. Was preventative care performed? □ Yes □ No If yes, check type: □ fluoride □ cleaning □ sealant □ other
3. Is there evidence of restoration history/past caries experience? □ Yes □ No
4. Are untreated dental caries present now? □ Yes □ No
5. Is further treatment needed? □ Yes □ No If yes, please complete below.

   Specify type of treatment needed: _____

   Time frame in which treatment should be completed: □ urgent □ within 3 months □ within 6 months □ other: _____

   Number of treatment appointments needed: _____ Date treatment is scheduled: ____/____/____
6. Was patient referred for treatment? □ Yes □ No Referred to: Name _____

   Phone Number: _____

   Appointment date: ____/____/____
7. _____ ____/____/____ _____

   Dentist's Signature Date Dentist's Printed Name and Office Number (or stamp)

DENTAL FOLLOW-UP TREATMENT RECORD

1. Dental treatment date: ____/____/____ Type of treatment performed: _____
2. Is any further treatment needed? □ Yes □ No Date further treatment is scheduled: ____/____/____
3. Comments: _____
4. _____ ____/____/____ _____

   Dentist's Signature Date Dentist's Printed Name and Office Number (or stamp)

AFTER COMPLETION, YOU MAY FAX THIS FORM DIRECTLY TO HEAD START AT: (574)722-3447.