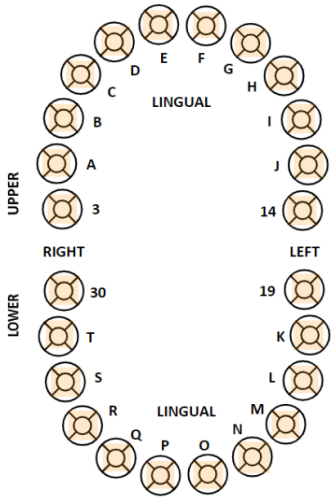
CMCCAA HEAD START DENTAL FORM

Child's Name: _____ Date of Birth: _____

ORAL CONDITION

missing (⊗), decayed (⊗), or filled (●); indicate restorations you perform in item 4.



Treatment Provided:

___ Exam

___ X-ray

___ Prophylaxis (cleaning)

___ Restoration

___ Sealants

___ Fluoride

___ Fluoride Supplement

Treatment Needed:

___ No treatment at this time

___ All treatment completed

___ Fillings

___ Routine preventive services

___ Referral to Pedodontist

___ Other: _____

_____

Date of next appointment: _____

Comments:

Date of Service: _____

Dr. Signature: _____

Dr. Name (print): _____

Clinic: _____

Address: _____

Phone: _____ Fax: _____

***Please return this form to:**
CMCCAA Head Start
150 Lafayette Rd.
Clarksville, TN 37042
Phone: (931) 896-1800
Fax: (931) 542-4671
*Please contact the agency for dental reimbursement guidelines