

ELKHART AND ST. JOSEPH COUNTIES HEAD START CONSORTIUM

245 North Lombardy Drive, Door 1, South Bend, IN 46619

Phone: (574) 393-5864 Fax: (574) 283-8108

DENTAL EXAMINATION FORM

Date of Exam: _____

Child's Name: _____ DOB: ____/____/____

Contact Information: _____

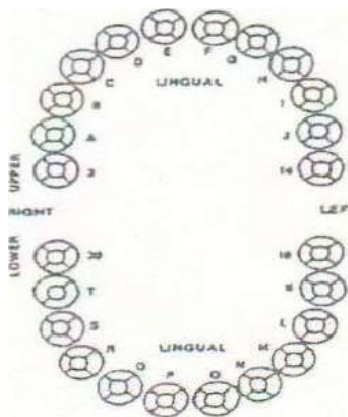
Parent/ Guardian Name: _____

Check All That Apply:

- | | |
|---------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Exam completed today | <input type="checkbox"/> Fluoride treatment today |
| <input type="checkbox"/> Radiographs completed | <input type="checkbox"/> Prophylaxis today |
| <input type="checkbox"/> Fluoride varnish applied today | <input type="checkbox"/> Oral hygiene instruction given |
| <input type="checkbox"/> Other: _____ | |

Further Dental Needs:

- | | |
|--------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Routine preventive care | <input type="checkbox"/> Comprehensive exam and radiographs |
| <input type="checkbox"/> Restore existing caries | <input type="checkbox"/> Refer to pediatric dental specialist |
| <input type="checkbox"/> Other: _____ | |



Please list any needed treatment:

Comments:

Dentist Signature: _____

Printed Name of Dentist: _____

Dentist Address: _____

Dentist Phone #: _____ Fax #: _____

Return Appointment Date: _____