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: ____

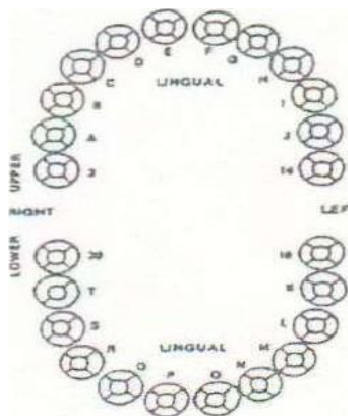
Parent/ Guardian Name: ____

Check All That Apply:

____ Exam completed today
____ Radiographs completed
____ Fluoride varnish applied today
____ Fluoride treatment today
____ Prophylaxis today
____ Oral hygiene instruction given
____ Other:____

Further Dental Needs:

____ Routine preventive care
____ Restore existing caries
____ Comprehensive exam and radiographs
____ Refer to pediatric dental specialist
____ Other:____



Please list any needed treatment:

____
____
____
____

Comments:

____
____
____
____

Dentist Signature: ____

Printed Name of Dentist: ____

Dentist Address: ____

Dentist Phone #: _____________________________________ Fax #:_____________________________________

Return Appointment Date:____