ELKHART & 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:

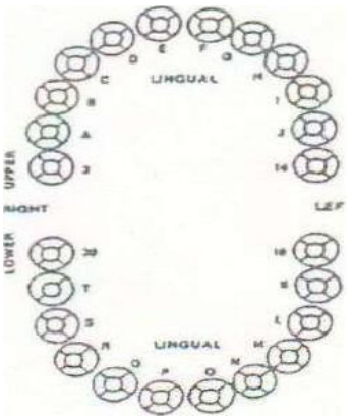
____ Exam completed today
____ Radiographs completed
____ Fluoride varnish applied today
____ Other: _____

____ Fluoride treatment today
____ Prophylaxis today
____ Oral hygiene instruction given

Further Dental Needs:

____ Routine preventive care
____ Restore existing caries
____ Other: _____

____ Comprehensive exam and radiographs
____ Refer to pediatric dental specialist



Please list any needed treatment:

_____
_____
_____
_____

Comments:

_____
_____
_____
_____

Dentist Signature: _____

Printed Name of Dentist: _____

Dentist Address: _____

Dentist Phone #: _____ Fax #: _____

Return Appointment Date: _____