Head Start Examen Dental

Nombre del niño:	Center/Class:
Nombre del padre:	Dia de Nacimiento de su niño/a:

DENTIST INFORMATION

Dentist Name:	Phone Number: ( ) -
Clinic Name (if different):	Fax Number: ( ) -
Clinic Address:	
City/State/Zip code:	

SCREENING AND TREATMENT RECORD

(List recommended services in order)

Tooth # or Letter	Surfaces	Description of work	Treatment Approved	Date Service Performed MO	DAY	YR	Actual Charges (fee)	

CHILD SCREENING RESULTS

- ❑ NEED TREATMENT (restoration, pulp therapy, extra
- ❑ OTHER_____
- ❑ NO PROBLEMS

Approximate number of visits needed: _____

Approximate cost: _____

Dentist Signature: _____ Date: _____

CHILD DENTAL WORK COMPLETION

Only complete this section if all dental work is accomplished and the child has no more

I certify that I have completed the service(s) listed in "SCREENING AND TREATMENT RECORD", and that the charges do

Dentist Signature: _____ Date: _____

Por lo presente yo autorizo que pueden liberar cualquier información del examen o tratamiento relacionado con Head Start a SUU Head

Padre/Guardian Firma

1st Copy-- Head Sta 2nd Copy-- Provider