hamilton county esc
EARLY LEARNING PROGRAM
924 Waycross Road—Cincinnati Ohio 45240—513-674-4343

Learn More...
Do More...
Be More

Dental Form

Please return exam results to Head Start program. Fax to 513-589-3077.

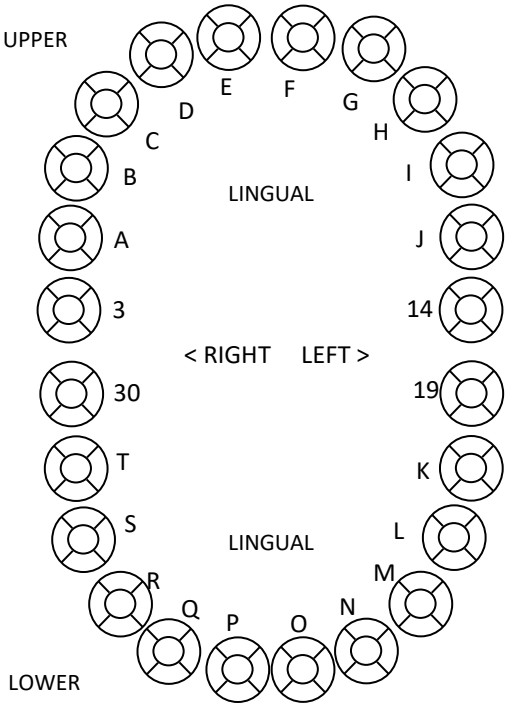
Child's Name: _____ Sex: [ ]Male [ ]Female D.O.B. _____

Parent/Guardian Name: _____ Phone: _____

Address: _____ Zip: _____ Center: _____

ORAL CONDITIONS BEFORE TREATMENT:

Missing Filled Decayed



What are results of Exam?

[ ] Healthy

[ ] Needs treatment

[ ] Monitor _____ for _____

Was any treatment done today? [ ] Yes [ ] No

Follow-up appointment:

Date: _____ Time___:___ AM / PM

Treatment Plan

If follow-up is needed, please explain the treatment plan:

Please check preventive services provided: [ ] Prophylaxis [ ] Fluoride [ ] Instruction in oral hygiene

Treatment services provided today: [ ] Restorations [ ] Pulp Therapy [ ] Extractions

[ ] Other: _____

Important: [ ] Check if all work for this child has been completed.

I hereby certify that the services listed above have been performed.

Date of Examination: _____ Dentist signature: _____

Address: _____ Phone: _____ Fax: _____