MARC HEAD START PROGRAM
Dental Examination Report

Direct Service Provider Agency: _____

HEAD START SITE: _____ **DATE of Exam:** ____/____/____

CHILD'S NAME: _____ SEX: _____ BIRTH DATE: ____/____/____ AGE:_____

PARENT(S) NAME: _____ PHONE NUMBER: _____

INSURANCE NUMBER (MEDICAID OR PRIVATE INSURANCE): _____

FAMILY ADVOCATE_____OFFICE NUMBER_____FAX_____

Diagnostic and Preventive Procedures Performed:

- ❑ Clinical Examination
- ❑ X-Rays
- ❑ Prophylaxis
- ❑ Fluoride application
- ❑ **Other** _____

Current Status:

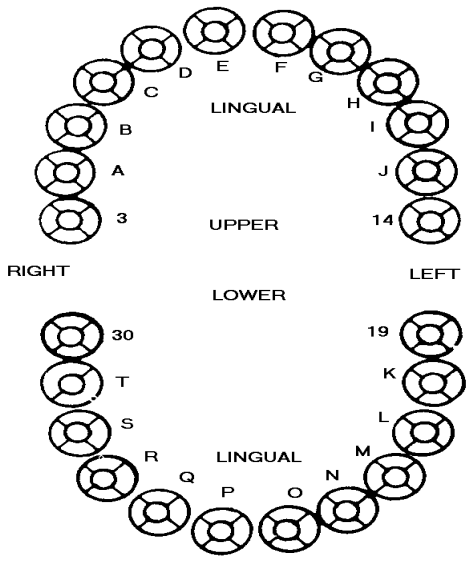
Cavities: _____ **(How Many)** **Recurrent decay around old fillings:** _____ **(How Many)**

Gums and supporting tissues:
- ❑ Normal & Healthy
- ❑ Slight Inflammation (gingivitis)
- ❑ Moderate Inflammation (gingivitis)
- ❑ Advanced disease (periodontitis)

Other: _____

Recommendation:

- ❑ No further treatment recommended at this time. Return in _____ months for an examination.
- ❑ Additional dental treatment is required. Treatment plan is identified below.



Patient scheduled to return for treatment on _____
Date

Tooth # or letter	Description of Dental Services Required

❑**All treatment has been completed as of** _____
Date

_____ _____ _____
Dentist Name (Please Print) Signature Date

_____ _____
Address, City, State & Zip Code Phone No.