Please return exam results to:

DAVIS/MORGAN/SUMMIT HEAD START/EARLY HEAD START

DENTAL EXAMINATION FORM

Family Enrichment Center
320 S. 500 E. • Kaysville, UT. 84037 • 801-402-0650 • Fax 801-402-0651

PARENTS: Head Start requires your child receives a dental examination. Follow-up work must also be completed if needed. Please fill out your child's name and date of birth and take this to your child's dental appointment. Remember Head Start needs a copy of this completed form.

(Head Start requiere que su niño recibe un examen dental. Si necesita tratamiento adicional, es requerido que se cumpla el tratamiento. Por favor llene el nombre de su niño y su fecha de nacimiento y lleva este forma a la cita del examen dental. La oficina dental llenará la porción de abajo. Usted regresará esta forma completa a Head Start.)

Child's Name:____ Date of Birth: ___________________
(Nombre del Niño) (Fecha de Nacimiento)

DENTIST: Please fill out the following information.

1- Received the following services:

Examination __________ X-ray __________ Cleaning __________ Fluoride__________

2- Results of the exam were: Please check one of the following.

☐ This exam completed services. (Child needed no further dental work at this time.)

OR

☐ Further dental work is needed.
The patient has an appointment for this work on: ________________________________

The approximate amount not covered by insurance $____________________________________
(Please attach a copy of the treatment plan if possible.)

Treatment has been received. Date completed: __________________________________

3- Name of Clinic/ Physician: and/or Clinic Stamp:_________________________________ Exam Date:____________

NOTE: After completion please email or fax directly to Head Start/Early Head Start at fecregistration@dsdmail.net or fax # 801-402-0651.