A Community Action Agency

Dental Treatment Report

To be completed by dental provider

1. Child's Name ______________________________ 2. Birth date _______/ ______/ _______

3. EHS/Head Start Center __________________________

4. Does this child need medication to receive dental care? ☐ yes ☐ no

5. Does child need Flouride supplements? ☐ yes ☐ no Did you prescribe Flouride supplements ☐ yes ☐ no

6. The following services were provided on DATE_________
   mo. day year

   Dental exam ☐ yes ☐ no
   Teeth cleaned and polished ☐ yes ☐ no
   Fluoride treatment ☐ yes ☐ no
   Tooth brushing ☐ yes ☐ no

   Additional treatment provided? ☐ yes ☐ no
   If yes, describe _______________________
   ____

7. Further treatment needed for this issue?
   ☐ yes ☐ no
   If yes, describe _______________________
   ____

   Expected date(s) of completion ___________

8. Exam not completed due to:
   ☐ uncooperative child
   ☐ medical concern

9. Referred to specialist? ☐ yes ☐ no
   Name ______________________________
   Phone ______________________________

10. 6-month Recall date: __________________

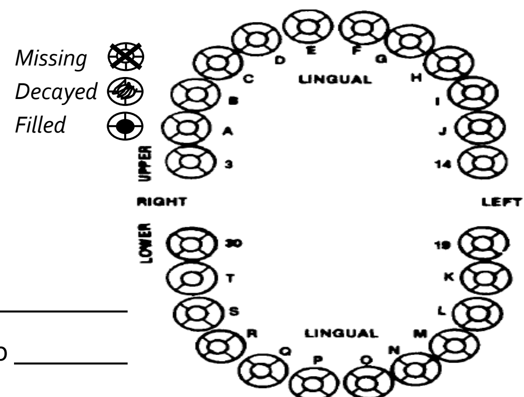
11. Are there any concerns regarding teeth, gums, mouth? ☐ yes ☐ no
    If yes, describe ______________________

12. Dentist's Name ____________________________ Phone _____________________
    Address____________________________ City ________________ Zip _______
    Signature ______________________________ Date _________________

EXAMINATION AND TREATMENT RECORD
(list recommended services in order)

Tooth # or letter	Surfaces	Date of services	Description of services

Oral conditions before treatment:
(Indicate restorations you performed)



Reviewed 1-2020