Danville Head Start Pre-K

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Fax 866-473-7705
"Educating Children, Empowering Families"

Dental Form

Name of Child:_____ **Date of Birth:** _____

Home Address: _____ **Sex** ☐ **M** ☐ **F**

_____

The above named child visited my office o: _____.
(date)

The following services were completed:

☐ **Fillings** ☐ **Extractions**

☐ **Fluoride** ☐ **Cleaning**

☐ **Other:** _____

At that time, all necessary dental corrections were made ☐ **N** ☐ **Y**

If No, fill in the following:

This child has the following dental needs:

☐ **Fillings** ☐ **Extractions**

☐ **Fluoride** ☐ **Cleaning**

☐ **Other:** _____

This treatment is scheduled on: _____
(appointment date)

Were referrals made for services? ☐ **N** ☐ **Y**

To whom was the child referred?_____

Dentist Signature: _____

Print Dentist Name: _____

Date: _____