

Early Learning Program

Dental Examination/Treatment Record

Student's Name: _____ Birthdate: _____

To be completed by Dental Provider: Date of most recent Dental Exam _____

Findings: (Check and complete all those that apply)

Hygiene Appointments:

_____ Was in for an examination and prophylaxis on _____

_____ Needs to schedule an examination and prophylaxis

_____ Is scheduled for a 6-month examination and prophylaxis on _____

Treatment Needs:

_____ No Treatment Needed

_____ Treatment needed (restorative, pulp therapy, extractions)

_____ All treatment was completed on _____

_____ First Phase of treatment completed on _____

_____ Has treatment appointment scheduled on _____

_____ Needs to schedule treatment

_____ Was a referral given for treatment? To Whom? _____

Dental Clinic: _____ Phone: _____

Dental Provider Signature: Date: _____ Date: _____

Send completed forms to:

Prairie Ridge Early Learning, 3031 Epiphany Ln, Eau Claire, WI 54703

Phone: 715-852-3603/ Fax: 715-852-3604