Dental Exam Form

Belmont Count CAC – Head Start, 100 West Main Street, St. Clairsville, Ohio 43950
Phone: (740) 695-0293 ext: 264 Fax: (740) 695-0869

To be completed by parent:

Child's Name:	DOB:
Dentist's Name:	
Head Start Center:	Teacher:

To be completed by Dentist:

1. Child Oral Health Summary

Date	Treatment Performed	Other Treatment Performed
	Cleaning Fluoride	
	Cleaning Fluoride	
	Cleaning Fluoride	
	Cleaning Fluoride	

2. Is baby bottle tooth decay present? Yes _____ No _____
3. Is child receiving topical fluoride? Yes _____ No _____
4. Is child receiving fluoride supplements? Yes _____ No _____
5. Is further treatment needed? Yes _____ No _____
6. If further treatment is needed approximately how many visits are needed? _____
7. Date of next appointment? _____
8. Recommendations for further treatment? _____

_____ _____
Dentist's Signature **Date**

_____ _____
Address **Phone Number**