

# Kerrville I.S.D. Early Childhood Center

## Head Start

1011 Third Street ~ Kerrville, TX 78028

(830) 257-1335 (830) 257-7885 fax

# Dental Exam Form

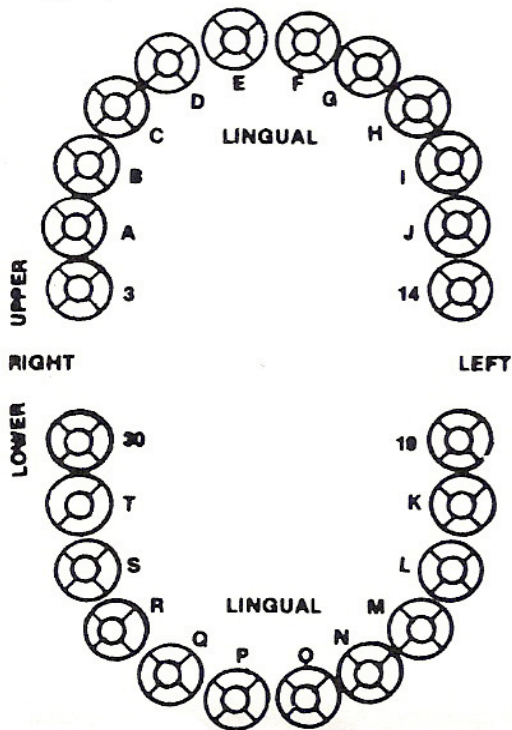
Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Are you the primary dental provider for this child? Yes      No

Is this the first time you have seen this child? Yes      No

Will you continue to be the child's primary dental provider Yes      No

**ORAL CONDITIONS BEFORE TREATMENT:** *missing* (☐), *decayed* (⊗), or *filled* (●); indicate restorations you perform in Item 10.



Tooth #	Description of <u>Today's</u> Work	Date Service Performed

**IMMEDIATE DENTAL NEEDS: (Check all that apply)**

- Cleaning       Sealants       Fluoride  
 Xrays       Fillings       Routine  
 No Problems       Other \_\_\_\_\_

All planned treatment [ \_\_\_ is; \_\_\_ is not ] complete. If not, explain here.

Comments/Notes: \_\_\_\_\_

Date of Next Routine Dental Exam: \_\_\_\_\_ Date of Follow-Up/Treatment \_\_\_\_\_

PRINT - Provider's Name

Office Telephone Number

Signature of Primary Dental Health Care Provider

Date