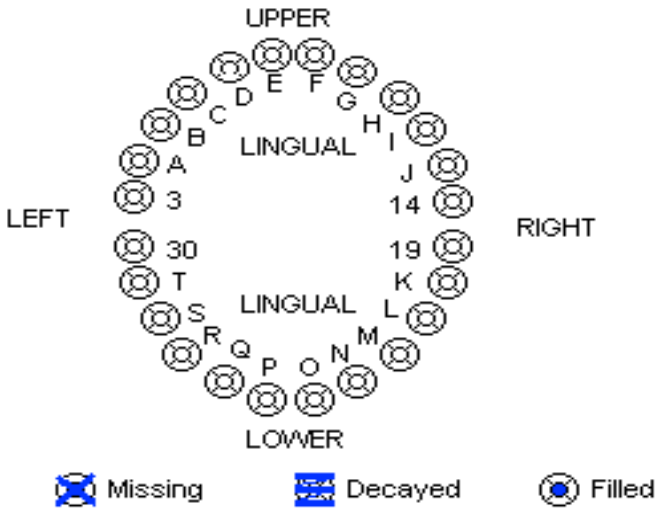
BCIU #22 Head Start / Early Head Start
DENTAL EXAM FORM - CHILD

Child's Name: _____ **Date of Exam:**_____
Date Of Birth:_____ **Sex:**_____

ORAL CONDITIONS:



DENTAL SERVICES (Check one or more):

☐ **A. TREATMENT NEEDED (Please List) _____**
☐ **B. TREAMENT COMPLETED**
☐ **C. CLEANING**
☐ **D. FLUORIDE**
☐ **E. Other (Please List) _____**
☐ **F. NO PROBLEMS,ROUTINE RECALL VISITS (Please List Date___/___/___)**

Dental Provider:_____

Address:_____ **Phone Number:**_____

Signature:_____ **Date:**_____