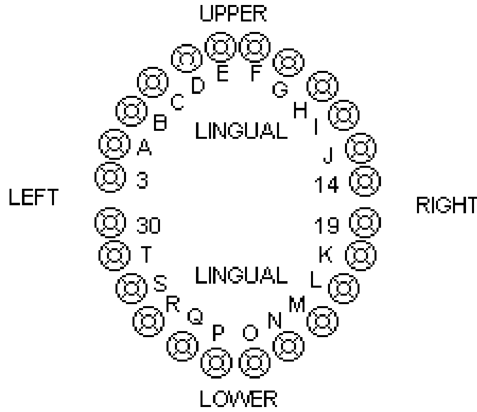
Kosciusko County Head Start/EHS
811 S Buffalo Street Warsaw, IN 46580
574-267-2451 • FAX 574-267-1998 • 800-315-2308

Dental EXAM Form

Child's Name: _________________________ **D.O.B.:** ______________________________

Parents: ______________________________ **Date of Visit:**__________________________



Key: Missing Decayed Filled

EXAM:
______Professional dental exam completed
______X-rays Taken
______Preventative Care Provided cleaning, fluoride, Oral health instruction

FINDINGS:
______ All findings are within normal limits.

RESTORATIVE CARE PROVIDED TODAY:
______ Fillings
______ Crowns
______ Extractions
______ Other ______________________________

Still Needed: ______ Fillings
______ Crowns
______ Extractions

______ Referral to: ________________________________
______Additional Information : ______________________

____

******Please complete the information below******

______ Treatment is currently **complete.**
______ Treatment is **not complete**.
______ Next exam /**cleaning due:** _______ **months**
____ **Follow up appointment scheduled**:___________________

The above service(s) were completed as indicated:

Signature of Dentist: ____________________________________ Date: ____________________

Printed name and phone/stamp: ____

Parents, Return this form to your child's teacher As soon as Possible or Request Dentist to fax:
Kosciusko Head Start/EHS 574-267-1998 Attention Health Coordinator