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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



 \_\_\_\_\_\_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\*\*\*\*\*\****

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\_\_\_\_\_\_ 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**



A Division of Cardinal Services, Inc. of Indiana • Serving Children and Families in Kosciusko County

Education • Health Services • Special Services • Family Services

Kosciusko County Head Start/EHS

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Fax (574) 267-1998

**Authorization for Use and Disclosure of Protected Health Information**

***AUTORIZACIÓN PARA OBTENER INFORMACIÓN MÉDICA O DENTAL***

**Child Information*/Información de niño/a:***

**Printed Name/ *Nombre del Niño*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Of Birth/ *Fecha de Cumpleaños*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address/*Dirección:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City/*Ciudad:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State /*Estado*\_\_\_\_\_\_ Zip/*Codigo:* \_\_\_\_\_\_\_**

**Telephone/*Telefono:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Information To Be Released/*Información que va a ser revelada:***

**Date of Service/ *Fecha de Servicio*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A.**

**DENTIST/ *Dentista*: Please complete this KCHS/EHS Oral Health Form (*Examen Dental*) and send to:**

**Kosciusko County**

**Head Start/Early Head Start**

**811 S Buffalo St.**

**Warsaw, IN 46580**

**Attention: Health Coordinator**

**Or FAX: 574-267-1998**

**Thank you/*Gracias,***

**Parent Signature/ *Firma:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date/ *Fecha:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Parent/Guardian Name/*Nombre de Padre/Guardian*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**