

Reach Dane Head Start
2096 Red Arrow Trail
Fitchburg, WI 53711
Fax: 608-275-6756

Dental Exam Form

Child's Name: _____ DOB: _____

Classroom: _____ Dental Clinic: _____

To be completed by dental office:

Date of Service: _____

Oral Health Care Services Delivered During Visit

Diagnostic/Preventative Services:

- ☐ Examination
- ☐ X-rays
- ☐ Risk Assessment
- ☐ Prophylaxis (cleaning)
- ☐ Sealants
- ☐ Fluoride Varnish
- ☐ Silver Diamine Fluoride
- ☐ Dental Sealants
- ☐ Other: _____

Please specify

Restorative/Emergency Care

- ☐ Fillings
- ☐ Silver Diamine Fluoride
- ☐ Crowns
- ☐ Extractions
- ☐ Dental Surgery
- ☐ Other: _____

Please specify

Future Oral Health Care Services:

- ☐ No treatment needed Next recall date: _____ (month/year)
- ☐ More appointments needed for treatment, next appointment date: _____
- ☐ Referred to Pediatric Dentist
 - ☐ Children's Dental Center: _____ (location)
 - ☐ Madison Pediatric Dental
- ☐ All treatment completed

Additional Information for Parents, Head Start Staff, and Medical Providers

Signature Section:

Dentist Name: _____

Address: _____

Dentist Signature: _____

Or Clinic Stamp: