# Reach Dane

2096 Red Arrow Trail
Fitchburg, WI 53711
Telephone: (608) 275 – 6740
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**DENTIST:** _____

## HEAD START DENTAL EXAMINATION

**Child's Name:** _____

**Date of Birth:** _____/_____/_____ **PROGRAM:** _____

*TO BE FILLED OUT BY CLINIC*

| **Dental Examination & Cleaning**<br>**Date: _____/_____/_____** | | **Dental Follow- up Work**<br>**Date: ____/____/____ & ____/_____/____** | |
|---|---|---|---|
| **Work Completed on this Date ↓** | **(Please check)** | **Work Done on this Date ↓** | **(Please check)** |
| **Cleaning** | | **Fillings:** | |
| **X-Rays** | | **Crowns:** | |
| **Topical Fluoride Treatment** | | **Hospital:** | |
| Other (Specify) _____ | | Other: | |
| Is **follow-up work** from this cleaning & exam **needed**?<br>**(Please circle) Yes No** | | Has patient **completed all needed treatment** at this exam?<br>**(Please circle) Yes No** | |
| If **yes**, has follow-up **treatment been arranged?**<br>**(Please circle) Yes No** | | If no, has follow-up treatment been arranged?<br>**(Please circle) Yes No** | |
| Number of appointments to complete needed work: **1 2 3 4** | | Number of appointments to complete needed work: **1 2 3 4** | |
| **Date(s) of upcoming appointments scheduled:**<br>_____/_____/_____ _____/____/_____ | | **Date(s) of upcoming appointments scheduled:**<br>_____/_____/____ _____/_____/_____ | |
| Has patient **missed any cleaning** appointments? #_____<br>**(Please circle)** Yes No | | Has patient **missed any follow up** appointments? #_____<br>**(Please circle)** Yes No | |

**Concerns Addressed/Information Given:**

Home Emphasis on Oral Hygiene
Harmful Oral Habits
Dietary Problems
Needs Fluoride Supplement

**How can Head Start assist this family**? _____

METHOD OF PAYMENT: (Please Circle) **Medical Assistance** **Private Insurance**

*** Billing Head Start Purchase Order #** _____

Dentist Name: _____
Address: _____ Phone: _____
Dentist Signature: _____

White: Master File