Reach Dane

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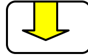
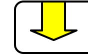
DENTIST: ____________

EARLY HEAD START DENTAL EXAMINATION

Child's Name: ____

Date of Birth: _____/_______/______ **PROGRAM/FA:** ____________________________

 ***TO BE FILLED OUT BY CLINIC*** 

Dental Examination & Cleaning **Date:** _____/______/______		**Dental Follow- up Work** **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**? **(Please circle)** **Yes** **No**		Has patient **completed all needed treatment** at this exam? **(Please circle)** **Yes** **No**	
If **yes**, has follow-up **treatment been arranged?** **(Please circle)** **Yes** **No**		If no, has follow-up treatment been arranged? **(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: _____/_____/_____ _____/____/_____		**Date(s) of upcoming appointments scheduled:** _____/_____/____ _____/_____/_____	
Has patient **missed any cleaning** appointments? #_________ **(Please circle)** Yes No		Has patient **missed any follow up** appointments? #_________ **(Please circle)** Yes No	

Concerns Addressed/Information Given:

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

How can Early Head Start assist this family? ________________________________

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

*** Billing Early Head Start Purchase Order #** _______________

Dentist Name: ____

Address: ______________________________________ Phone: _______________

Dentist Signature: ____

DENTAL EXAM FOLLOW UP INFORMATION SHEET ----- PARENTS COPY

Work that is needed at follow up appointments:
(Trabajo dental que se necesita en las citas de seguimiento)

Scheduled for (Fecha de la cita(s)): _____/______/_____ at ________:________ am / pm

(Please √ those that apply)

Filling(s) _______
(Empastes(s))

Caps/Crown(s) ______
(Funda/Corona(s))

Sealants ______
(Selladores)

X-Ray(s) ______
(Rayos X)

Hospitalization ______
(Hospitalización)

Back Tooth Extraction(s) ______
(Extracción de muela)

Front Tooth Extraction(s) ______
(Extracción de un diente frontal)

Spacer ______
(Implantes dentales)

Other ____________________
(Otra)

If Hospitalization Is Needed:
(Hospitalización necesaria)

Pre-Op Physical:

An appointment will need to be made with your primary physician before dental surgery can be completed.
(Una cita tendrá que ser hecho con su médico decabecera antes de cirugía dental puede ser completada.)

Scheduled for (Fecha de la cita(s)): _____/______/_____ at ________:________ am / pm

Dental Surgery:

Scheduled for (Fecha de la cita(s)): _____/______/_____ at ________:________ am / pm

Hospital: ______________________