Gulf Regional
Early Childhood Services

Head Start / Early Head Start - Documentation of Dental Care

Child's Name: _____ Date of Birth: _____
Center: _____

***Please complete Sections A, B, & C thoroughly.**

(A) Verification

This is to certify that the above-named child is one of my patients and was last seen in my office on
(date) _____ .

The following applies to this patient *(check all that apply):*

- ❒ Dental exam complete
- ❒ Needs no treatment at this time
- ❒ Treatment complete
  Date: _____
- ❒ Needs routine examination
  Month: _____
- ❒ Needs dental service(s) – *list in (C) below.*

(B) Oral Conditions Before Treatment

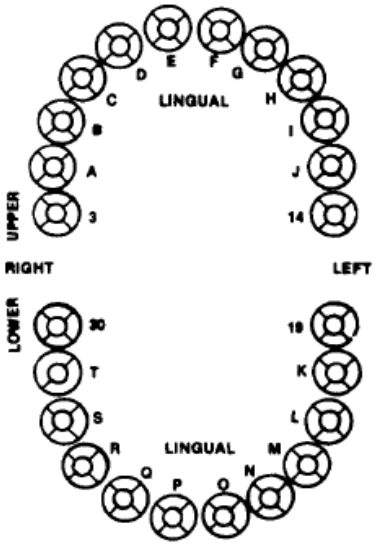
Use the below diagram to mark teeth as missing, decayed, and/or filled.
List any restorations performed in (C below).

Use the following symbols:

X = **Teeth that are missing.**

/ = **Teeth that are decayed.**

◯ = **Teeth that are filled.**



(C) Examination & Treatment Record. *List recommended services in order.*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Services Performed			ADA Procedure Number	Actual Charges (fee)
				Mo	Day	Yr		

Comments: _____

Dentist Signature: _____ Date: _____

Print Name: _____ Phone: _____

Next appointment date: _____