Adams County Head Start

Dental Treatment Form

PARENT(S), PLEASE COMPLETE:

Child's Name:_____ Date of Birth: _____

Head Start Center: _____ Phone: _____

Cost of Dental Services Covered By:

☐ Medicaid ☐ Private Dental Insurance: _____

☐ CHP+ ☐ Federal, State, Local Agency: _____

☐ Head Start ☐ Other: _____

☐ Parents/Guardians Self-Pay

TO BE COMPLETED BY DENTAL OFFICE ONLY

Please fax completed form to ACHS Health Department at 720-523-7992

Priority Level:

☐ (1) Needs Immediate Attention ☐ (2) Needs Attention Soon ☐ (3) Needs Routine Care

Professional Dental Services and Treatment Provided (check all that apply):

☐ Dental Examination / Date: _____ ☐ Sealants / Date: _____ ☐ Oral Hygiene Instructions _____

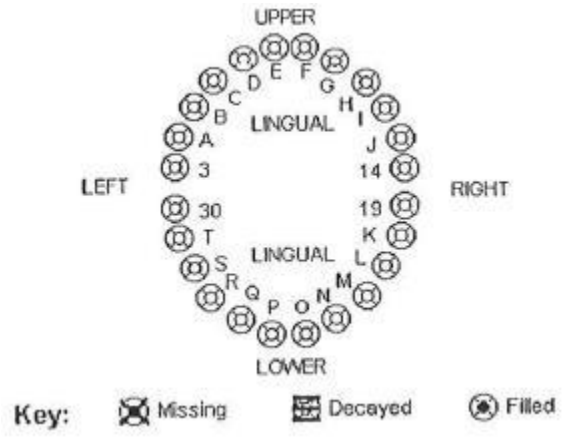
☐ X-Rays / Date: _____ ☐ Fillings / Date: _____ ☐ Cleaning/Prophylaxis / Date: _____

☐ Extractions / Date: _____ ☐ Fluoride / Date: _____ ☐ Crowns / Date: _____

☐ Parent Received Dental Ed / Date: _____

☐ Routine Recall Visits ☐ Dietary Problems ☐ Needs Fluoride Supplement

☐ Developmental Problems ☐ Harmful Oral Habits ☐ Other/Explain:



Notes/Comments:

Child Oral Health Summary:

Has all treatment been completed? ☐ Yes ☐ No

If treatment is not complete, please briefly explain treatment plan including number of remaining visits:

_____

OFFICE STAMP – If no stamp, please include:

Clinic Name: _____ Address: _____

Phone Number: _____ Date of **NEXT VISIT**: _____

If treatment is still needed

Dental Provider Signature: _____ **Signature Date:** _____

Revised 04/18