

# UMCHS - DENTAL EXAM RECORD

Child's Name \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

HS/EHS Center: \_\_\_\_\_ Insurance Provider: \_\_\_\_\_

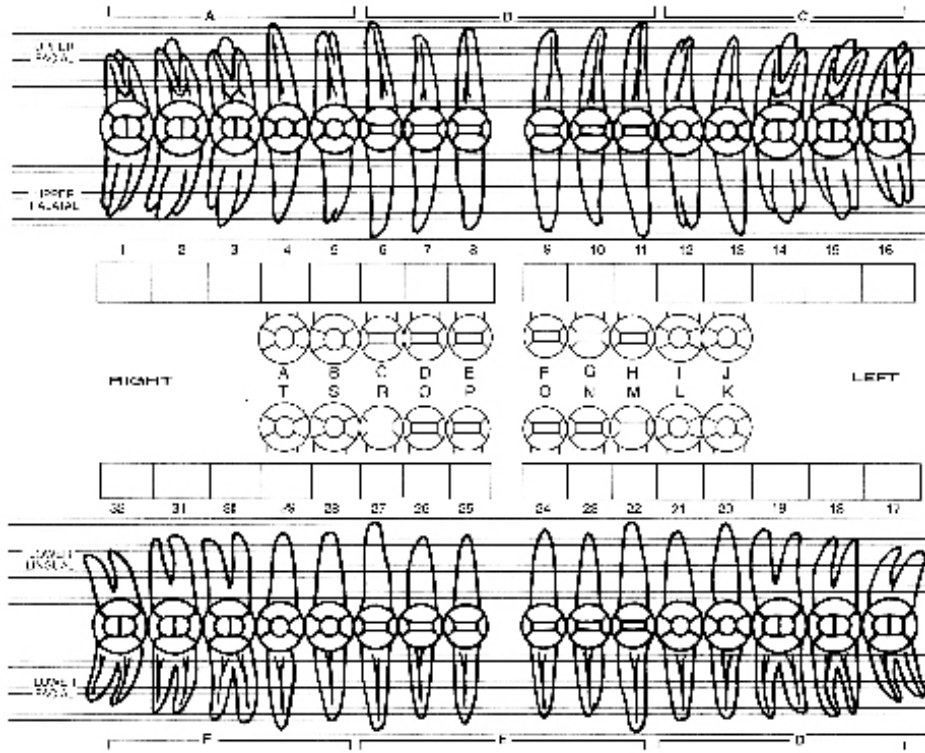
Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

**HISTORY**

**ALLERGIES:**

**MEDICATIONS:**

**REMARKS**



**DENTAL PROVIDER**

Please complete the following information for Head Start.

(Check "✓" All Boxes that Apply.)

**SERVICES COMPLETED**

- Oral Hygiene Instruction
- Topical Fluoride & Prophy
- Sealants Applied
- Systemic Fluoride Prescribed

**EXAM & TREATMENT SERVICES**

- Normal Exam, Healthy
- Treatment Indicated:
  - Treatment In Progress, \_\_\_\_\_ No. of Apts. Needed
  - Referred to: \_\_\_\_\_
- All Treatment Completed
- Return to Clinic: \_\_\_\_\_

**BILLING INFORMATION**

- Parent Paid Out of Pocket
- Private Insurance
- OHP/Medicaid  IHS/Tribal
- Head Start Voucher

DATE	TOOTH	TREATMENT PLAN	EST.	DATE	TOOTH	SERVICES RENDERED	FEE

Dentist Signature: \_\_\_\_\_ Phone: \_\_\_\_\_ Exam Date: \_\_\_\_\_