Storyteller Children's Center

DENTAL EXAMINATION REPORT – CONFIDENTIAL

May 2010

CHILD'S NAME (LAST)	(FIRST)	(INITIAL)	SEX (M / F)	BIRTHDATE (MONTH)	(DAY)	(YEAR)

CENTER / FCC PROVIDER / HOME EDUCATOR	SESSION
STORYTELLER CHILDREN'S CENTER	AM / PM / FD

SECTION A – TO BE COMPLETED BY PARENT OR GUARDIAN

AUTHORIZATION FOR RELEASE OF INFORMATION / AUTORIZACIÓN PARA REVELAR INFORMACIÓN

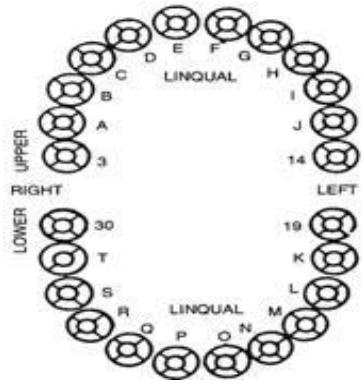
I authorize release of medical information contained in this report to Storyteller Children's Center. / Yo autorizo revelar información médica contenida en este reporte a Storyteller Children's Center.

SIGNATURE OF PARENT OR GUARDIAN / FIRMA DEL PADRE O TUTOR _____ DATE / FECHA _____

SECTION B – TO BE COMPLETED BY DENTAL CARE PROVIDER (SEE NOTE BELOW)

Please complete and return to the child's parent or guardian or to Storyteller Children's Center. As a Head Start and Early Head Start grantee, we are required by law to obtain a health care professional's determination as to whether the child is up-to-date on a schedule of well child care as required by the Federal Head Start Act and the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program of the Medicaid agency of the State, which includes oral health assessments and treatment. Dental follow-up and treatment must include fluoride supplements and topical fluoride treatments as recommended by dental professionals in communities where a lack of adequate fluoride levels has been determined or for every child with moderate to severe tooth decay; and other necessary preventive measures and further dental treatment as recommended by the dental professional. Thank you.

ORAL CONDITIONS BEFORE TREATMENT



EXAMINATION AND TREATMENT RECORD

Please list services performed, including examination (for example, complete exam, x-rays, visual exam only), preventive care (fluoride application, prophylaxis, sealant application), and/or treatment (restoration, pulp therapy, extraction). Attach additional sheets, if needed.

TOOTH # OR LETTER	SURFACES	DESCRIPTION OF SERVICE	DATE SERVICE PERFORMED MO	DAY	YR

FOLLOW-UP RECOMMENDATIONS

Please check one or more remaining dental needs (or No Problems, if none). Include date of next appointment or scheduled recall visit.

☐ TREATMENT (restoration, pulp therapy, extraction)
☐ PREVENTIVE CARE (fluoride application, prophylaxis, sealant application)
☐ FURTHER EVALUATION (complete exam, x-rays)
☐ OTHER: _____

☐ NO PROBLEMS

Date of next appointment or scheduled recall visit: _____

SERVICE LOCATION (Please include name, address, and telephone number):

REFERRED TO:
NAME TELEPHONE NUMBER

REFERRED TO:
NAME TELEPHONE NUMBER

I certify that I have completed the service(s) listed in the Examination and Treatment Record.

SIGNATURE OF PROVIDER _____ DATE _____