Date Received at Center: _____

Head Start Program Dental Form

Part 1 (COMPLETED BY PARENT OR STAFF)

Patient Name _____ Date of Birth _____

Parent/Guardian Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Part 2 (Licensed dental professional must complete this section)

Is patient up to date with oral health recommendations: ☐Yes ☐No (**Please comment below**)

Last Date of Service: _____

Services Provided: ☐Propholaxis/Exam ☐Treatment (extraction, filling, etc.)

Recommendations:

6 Month Check Up **Scheduled** ☐No ☐Yes **Date:** _____/_____/_____

Additional work is needed (**Please comment below**)

Comments:

Provider Signature **Office** **Date**

These materials were funded in whole or in part under a grant awarded by the Michigan Department of Lifelong Education, Advancement, and Potential.