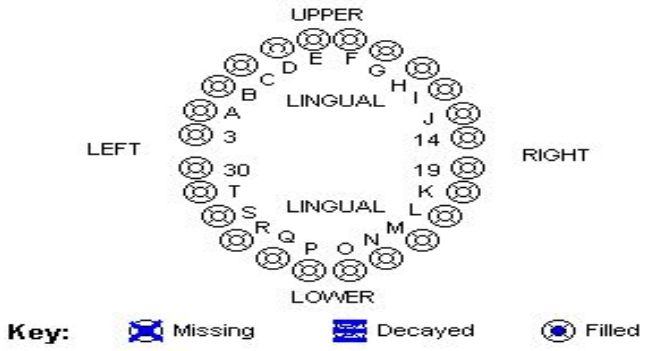
REGION IX HEAD START: DENTAL EXAM
143 El Paso Road, Suite 1, Ruidoso, NM 88345
Phone: 575-257-2368 / Fax: 855-625-5183

1. Fax or mail to the above address. The parent has signed an authorization to release medical information.
2. Complete and PRINT all areas of the dental form, print provider name, and enter phone number.
3. * If treatment is needed please indicate on this form.
4. Families are responsible for payment unless the Head Start Director provides the Dentist with written authorization for payment prior to the examination.
5. **The Dental Exam Form is not valid unless completed in full that includes the signature of the Dentist and date of the exam.**

Tooth Letter	Description of Work	Date of Service Performed

Child's Name: _____ Date of Birth:



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Dental Needs	□Today's DENTAL Exam is OK, (No Needs at this time) ☐ Preventative Services ☐ Bitewing Films ☐ Cleaning ☐ Fluoride Supplement ☐ Fluoride Varnish ☐ Oral Hygiene Instruction ☐ Sealants ☐ Other ☐ Dental Treatment* □Cleaning: Follow-up appointment for cleaning:_____ □Needs Dental Treatment: Follow-up appointment for treatment:_____
Dental	

H 09/18 **Note: This exam is valid only with the Signature of the Provider and the date of the exam.**

Services Received Today	☐ □Preventative Services Received* ☐ Bitewing Films ☐ Cleaning ☐ Fluoride Supplement ☐ Fluoride Varnish ☐ Oral Hygiene Instruction ☐ Sealants ☐ Other(Please explain)_ ☐ □Received Dental Treatment* ☐ Extraction ☐ Pulp Therapy ☐ □Restoration ☐ Other(Please explain)_____

Provider Signature: _____ **Date of Service:** _____

Print Provider Name: _____ **Telephone Number:** _____

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