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Children Families Communities Staff
CAP, Inc.
0-5 Head Start
Gratiot, Ionia, Isabella, Montcalm (Clinton)

Dental Treatment Report

Child's Name:_____ Birth Date:_____

1. Are there any concerns regarding this child's teeth, gums, or mouth? ☐ yes ☐ no
   If yes, describe:_____

2. The following services were provided on **DATE:**_____
   Dental exam ☐ yes ☐ no
   Teeth cleaned and polished ☐ yes ☐ no
   Fluoride treatment ☐ yes ☐ no

   Additional treatment provided? ☐ yes ☐ no
   If yes, describe: _____
   _____
   _____

3. Further treatment needed for this issue?
   ☐yes ☐ no
   If yes, describe:_____
   _____
   Expected date(s) ofcompletion: _____

4. Exam not completed due to:
   ☐uncooperative child
   ☐medical concern

5. Referred to specialist? ☐ yes ☐ no
   Name: _____
   Phone: _____

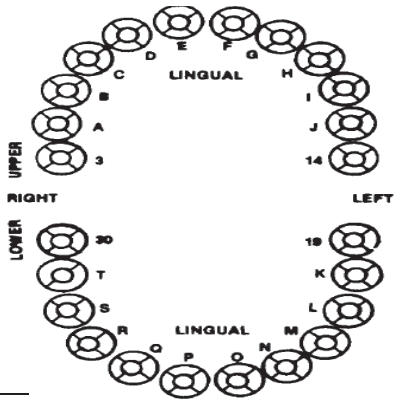
6. Next appointment date: _____

EXAMINATION AND TREATMENT RECORD
(List treatment completed)

Tooth # or letter	Surfaces	Date of services	Description of services

Oral conditions before treatment:

Missing
Decayed
Filled



Dentist: _____ Phone: _____

Address:_____ City:_____ Zip:_____

Signature:_____ Date:_____

Updated