*Three Rivers Community Action, Inc.*
*1414 North Star Drive, Zumbrota, MN 55992*
*Phone: 507-322-3103 Fax: 507-933-4481*

# Child Health Record Dental

| Last name | First | Middle | Birthdate | Site | Date |
|---|---|---|---|---|---|
| | | | | | |

| Parent/Guardian Name | Address | City, State, Zip | Telephone # |
|---|---|---|---|
| | | | |

| Child's Medical Insurance | Child's Medical Insurance Number |
|---|---|
| | |

Please return this completed form to Three Rivers Head Start
at the address on the top of this form.

## Dentist Report

This child received the following treatment in my office:

- ☐ Dental Examination/BSS
- ☐ X-rays
- ☐ Topical Fluoride Application
- ☐ Cleaning
- ☐ Sealant Application
- ☐ Fillings
- ☐ Extractions
- ☐ Steel Crowns
- ☐ Space Maintainers
- ☐ Other _____

☐ ALL Treatment IS complete.

☐ ALL Treatment IS **NOT** complete - the following is still needed:

- ☐ Dental Examination
- ☐ X-rays
- ☐ Topical Fluoride Application
- ☐ Cleaning
- ☐ Sealant Application
- ☐ Fillings
- ☐ Extractions
- ☐ Steel Crowns
- ☐ Space Maintainers
- ☐ Other _____

Comment: _____

_____

Next Appointment DATE: _____

_____
Provider's Signature

| _____ | _____ | _____ |
|---|---|---|
| PRINT PROVIDER'S Name | PROVIDER'S Telephone | Date of Exam |

_____
PROVIDER'S Address