CHILD DENTAL ASSESSMENT

Child's Name:_____ Sex:_____ Birthdate:_____

Parent's Name:_____ Head Start Unit:_____

Address:_____

PAYMENT SOURCE: ( ) T-19 ( ) CHIP Program ( ) IHS ( ) Private Insurance ( ) Head Start

IS THIS CHILD NOW RECEIVING? ____Fluoridated Wate ____Topical Fluoride Application ____Fluoride Supplement:
(check if receiving)

Exam Date: _____

PREVENTATIVE: ( ) Cleaning ( ) Flouride/Flouride Varnish
(Please mark all that apply)

Exam Results: ( ) No Needs ( ) Routine Recall ( ) Treatment Needed ( ) Treatment Complete

Follow-Up/Appointment Date: _____

Referred to : _____

Description of Work That needs to be Done:

PROVIDER SIGNATURE: _____ **DATE:** _____

DENTAL PROVIDER: _____
(PLEASE PRINT)

ADDRESS: _____

_____

TELEPHONE #: _____

RETURN COMPLETED FORM TO: **South Central Child Development, INC.**
401 Walnut Street SW
Wagner, SD 57380
Phone # 1-877-384-3683
Fax # 605-384-5696 (fax is possible)