Center_____ ID# _____

Medicaid # _____

DENTAL HEALTH RECORD

Name of Child (Last, First, Middle)

C.L.M Community Action Agency
Head Start Program
P.O. Box 70 – 524 Ashmun Street
Sault Ste. Marie, MI 49783

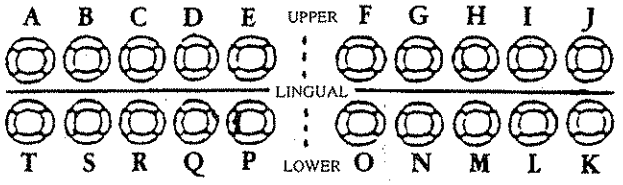
Patient's Address:

City State/Zip County

Birthdate Sex_____ Is water flouridated? ☐ No ☐ Yes

Previous Dental Care ☐ No ☐ Yes

RIGHT PRIMARY TEETH



PRIMARY TEETH LEFT Y

PLACE AN "X" ON TEETH REQUIRING TREATMENT

INITIAL SCREENING AND TREATMENT

SERVICES PROVIDED: (PLEASE RECORD EACH TREATMENT ON SEPARATE LINE)

MONTH	DAY	YEAR	TOOTH	SURFACE	MATERIAL	DESCRIPTION OF WORK	FEE
						TOTAL	

This is NOT a Bill.

TREATMENT CODE: SURFACES: M–Mesial D–Distal O–Occlusal L–Lingual I–Incisal B–Buccal or Labal
MATERIALS: A–Amalgam S–Silicate P–Acrylic C–Steel Crown O–Other

TREATMENT

ADDITIONAL TREATMENT NEEDED (DO NOT DATE UNTIL RENDERED)
SERVICES PROVIDED: (PLEASE RECORD EACH TREATMENT ON SEPARATE LINE)

MONTH	DAY	YEAR	TOOTH	SURFACE	MATERIAL	DESCRIPTION OF WORK	FEE
						TOTAL	

ESTIMATED COST OF TREATMENT

$ _____

Agency Authorization

(Initials) _____

(Date) _____

IMPORTANT:

☐ _____ Appointment date for additional treatment.

☐ (Check) All work for the child has been completed.

☐ (Check) No treatment necessary.

White copy: Head Start
Yellow copy: Providing agency
Pink copy: Patient

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED.
DENTIST'S SIGNATURE AND ADDRESS

DENTIST'S LICENSE NUMBER DATE