Community **Action** Partnership of Ramsey & Washington Counties

Annual Dental Exam & Treatment

Child's Name: _____ Date of Birth: _____

Date of most recent exam: _____

Date of treatment following exam (if applicable): _____

Dental Provider's Signature: _____

Dental Clinic Name / Address / Telephone Number: _____

_____

The following was completed:

_____Dental Examination
_____X-Rays TAKEN _____X-Rays READ
_____Fluoride Application
_____Cleaning
_____Sealants
_____Fillings
_____Extractions
_____Steel crowns
_____Space maintainers
_____Other, Explain: _____

_____ALL Treatment IS complete.

OR

_____Treatment is NOT complete. The following is still needed:

_____TAKE X-Rays
_____READ X-Rays
_____Sealant Application
_____Fillings
_____Extractions
_____Steel Crowns
_____Space maintainers
_____Other, Explain: _____

Plan to Complete Treatment: _____

_____

NOTE: Head Start requires a dental exam with preventive services such as fluoride, and recommended treatment completed each year. Head Start families have been instructed to apply for MN Care if they do not have insurance. If ineligible for MN Care, Head Start will cover the cost of dental services at the MN Care allowable rate. Services, and their cost, must have prior approval from the Head Start Health Services Manager for payment: 651-603-5907. We greatly appreciate the services you are providing for our enrolled families.