



COMMUNITY ACTION - HEAD START

450 North Syndicate Street, Suite 5 St. Paul, MN 55104
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ANNUAL DENTAL EXAM & TREATMENT

Child's Name: _____ Birth Date: _____

Date of most recent exam: _____

Date of any treatment following exam: _____

Dentist's Signature: _____

Dental Clinic Name/ Address/ Telephone Number: _____

The following was completed:

- | | |
|--|--|
| <input type="checkbox"/> Dental Examination | <input type="checkbox"/> Fillings |
| <input type="checkbox"/> X-Rays TAKEN <input type="checkbox"/> X-Rays READ | <input type="checkbox"/> Extractions |
| <input type="checkbox"/> Fluoride Application | <input type="checkbox"/> Steel crowns |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Space maintainers |
| <input type="checkbox"/> Sealants | <input type="checkbox"/> Other, Explain: _____ |

_____ **ALL Treatment IS complete.**

OR

_____ **Treatment is NOT complete. The following is still needed:**

- | | |
|--|--|
| <input type="checkbox"/> TAKE X-Rays | <input type="checkbox"/> Extractions |
| <input type="checkbox"/> READ X-Rays | <input type="checkbox"/> Steel Crowns |
| <input type="checkbox"/> Sealant Application | <input type="checkbox"/> Space maintainers |
| <input type="checkbox"/> Fillings | <input type="checkbox"/> 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.