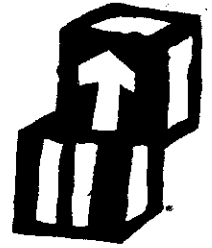




Ulster County Community Action, Inc.  
 Early Head Start/Head Start  
 70 Lindsley Avenue  
 Kingston, NY 12401  
 Phone: 845-338-8750  
 Fax: 845-339-4968



**Dental Information Form**

Regular visits to the Dentist are very important to help save teeth and keep our children's smiles healthy! Because dental health is so important to young children, we require every child should see a dentist. Please schedule an appointment for your child as soon as possible. Bring this form to your appointment for your dentist to complete, then return to us. Thank you!

Child's Name: \_\_\_\_\_ was seen by \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ on Date: \_\_\_\_\_

<p><b>Service provided today</b></p> <p>Exam _____</p> <p>Prophylaxis _____</p> <p>Topical Fluoride application _____</p> <p>Sealants _____</p> <p>X-rays _____</p> <p>Treatment (Please specify): _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>KEY</b></p> <p>Decay =      Filled=0      Missing = X</p> <p>Upper Jaw</p> <p>Lower Jaw</p>	<p><b>Further Dental needs</b></p> <p><input type="checkbox"/> X-Rays</p> <p><input type="checkbox"/> Filling</p> <p><input type="checkbox"/> Sealants</p> <p><input type="checkbox"/> Crown</p> <p><input type="checkbox"/> Extraction</p> <p><input type="checkbox"/> Other</p> <p>_____</p> <p>_____</p>
---	---	---

**Status of Dental Care**

\_\_\_\_\_ All necessary service is complete at this time.

\_\_\_\_\_ Will need a routine dental exam in the month of \_\_\_\_\_ year \_\_\_\_\_

\_\_\_\_\_ This child is in the process of ongoing treatments      Dates for return appointments: \_\_\_\_\_

\_\_\_\_\_ This child cannot be examined at this time.      Reason: \_\_\_\_\_

Recommendation: \_\_\_\_\_

\_\_\_\_\_ I have referred this child for further dental examination and/or treatment. To: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Head Start Requirement)

Printed or stamped Dentist Name, Address, and Phone number:

