Dear parent/guardian, all children must have a dental examination at least annually beginning at one year old. Please request that your child's dentist complete this form and return it to Head Start/Early Head Start. A list of area dentists is available upon request. Thank you for your cooperation.

SHARE HEAD START/EARLY HEAD START

Mailing address: Post Office Box 10204, Greenville, SC 29603 Phone 864-233-4128 Fax 864-233-4019
Location: 254 South Pleasantburg Drive, Greenville, SC 29607 **www.sharesc.org**

Dental Examination/Treatment

Name____ Date of Birth _______________
Address ____
Phone _________________________ Head Start Center ______________________________
Dental Insurance (check all that apply) ___ Medicaid ___ Private ___ Other ___ None

Date of Visit _______________Services provided this visit include: (please check all that apply)

Diagnostic/Preventive

- ___ Examination
- ___ X-rays
- ___ Cleaning
- ___ Fluoride
- ___ Dental sealants

Restorative/Emergency

- ___ Filling
- ___ Crowns
- ___ Extractions
- ___ Emergency care

___**Counseling/Anticip. Guidance**

___ **Other** ____________________
(Please specify)

___ **Referral to Specialty Care**
____
(Name of Specialist)

Please check all that apply:

___ No treatment is recommended. Teeth exhibit **no** signs of decay/cavities.

___ Teeth exhibit **moderate/few** decay/cavities, recommended treatment is in progress and next appointment is scheduled for ____________________ (date).

___ Teeth exhibit **severe/multiple** decay/cavities, recommended treatment is in progress and next appointment is scheduled for ____________________ (date).

___ **TREATMENT IS NOW COMPLETE** and recommended treatment was completed on __________________ (date).

______________________________ is a dental home for this patient. ___ YES ____NO
Name of Provider

Dentist Name ______________________________

Address_________________________ Dentist Signature ___________________________
____
Phone _________________________
Fax _________________________ Date of Statement ___________________________