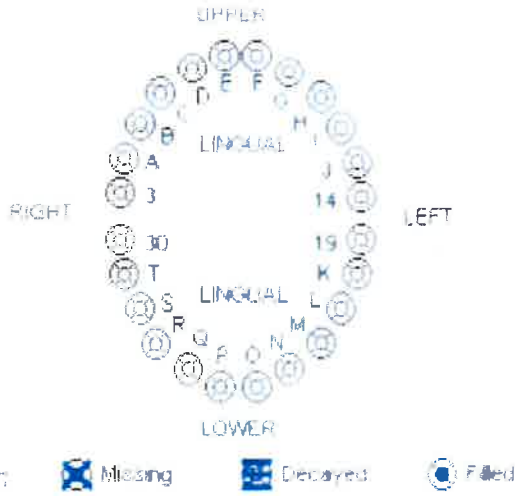
# LEADS Head Start/Early Head Start
## Dental Exam

Child's Name: Angus P Adhikari Center: BL Date of Birth: 9/4/12

Parent's Name: _____ Date of Exam: 9/6/17

**ORAL CONDITION:** Before Treatment (using key)
Indicate restorations.




| Description of Work | Month | Day | Year |
|---|---|---|---|
| X-rays | 9 | 6 | 2017 |
| Prophy | 9 | 6 | 2017 |
| Exam | 9 | 6 | 2017 |
| Fluoride | 9 | 6 | 2017 |
| | | | |
| | | | |
| | | | |

Please check ALL appropriate information pertaining to this child:

( ) Needs treatment (restoration, pulp therapy, extraction)
(X) No treatment needed at this time
( ) Treatment is complete [please *circle*] YES NO
( ) Routine recall visit due _____
( ) Recommend fluoride supplement _____
( ) Is this child up to date on scheduled age appropriate preventive care [*please circle*] YES NO
( ) Other _____

Name of Provider: (please print) David Wise Date: _____

Provider Signature: _____ Phone: _____

Provider Address: _____