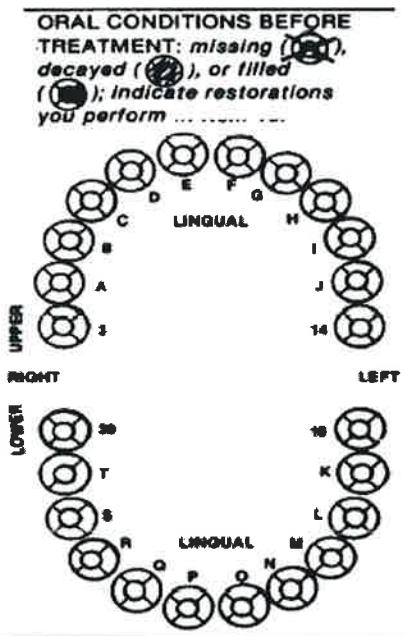
LEADS Dental Exam

Phone: (740) 258-6117
FAX: (740) 345-4303

Complete and return to: LEADS Head Start/Early Head Start

Child's Name (Please print or type)	**Center –**	Childs Date of Birth
Joseph Burch		6-20-13
Parent's Name	**Date of Exam**	
Theresa Burch	5-3-17	



Description of Work	Month	Day	Year
Exam	5	3	17
Cleaning	5	3	17
fluoride	5	3	17

Please check ALL appropriate information pertaining to this child:

( ) ~~Needs~~ treatment (restoration, pulp therapy, extraction) #E, F caries

( ) 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 (please specify)_____

Name of Dentist (please print)	Samir Merchant	**Telephone Number**	740 788 8084
Street Address	613 Hebron Rd	**City, State, Zip Code**	Heath OH 43056
Dentist Signature		**Date of Exam**	5/3/17

RECEIVED 5.4.17

ENTERED ON: 5/4/17 BY:

Dental form 1516