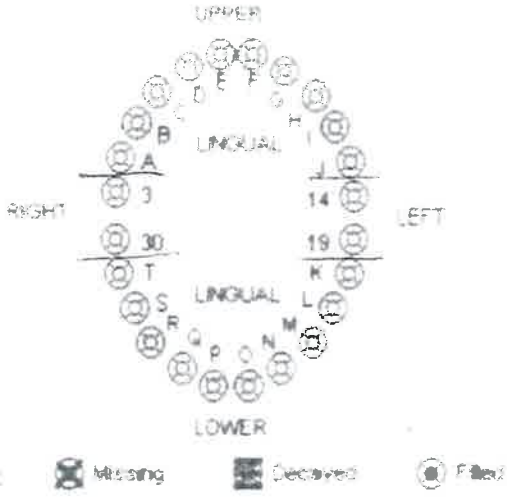
Action LEADS

LEADS Head Start/Early Head Start
Dental Exam

Child's Name: Leland Williams Center: Newark Date of Birth: 10/18/16

Parent's Name: Jennifer Williams Date of Exam: 10/18/16

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



Description of Work	Month	Day	Year
Cleaning	10	18	2016

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) Mujish Patel Date: 10/18/16

Provider Signature: _____ Phone: 740-522-4803

Provider Address: 30th Street Heath OH 43056

RECEIVED 10/19/16 NF

ENTERED ON: 10/19/16 BY: NF

2016