Community Action LEADS — HELP THAT LEADS YOU IN THE RIGHT DIRECTION

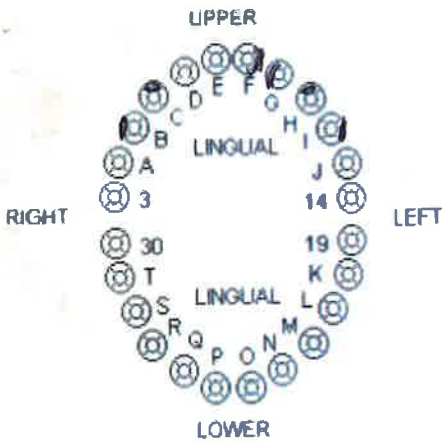
LEADS Head Start/Early Head Start
Dental Exam

Child's Name: Adelynn Peters Date of Birth: 4/8/13

Parent's Name: Jada peters Date of Exam: 11/6/17

Center: Newark Center Phone: 740-345-6415 Fax: 740-345-2305

ORAL CONDITION: Before Treatment (using key)



Key: Missing Decayed Filled

Description of Work	Month	Day	Year
Exam	11	6	17
Prophy	11	6	17
FL	11	6	17

Indicate restorations.

Please check ALL appropriate information pertaining to this child:

( ) Needs treatment (restoration, pulp therapy, extraction)
( ) No treatment needed at this time
( ) Treatment is complete [please *circle*] YES NO
(X) 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) _____ Date: 11-6-17

Provider Signature: R Mallek Phone: _____

Provider Address: Kids First Pediatric Dental Care 3539 Cliffhanger Way Zanesville, Ohio 43701

RECEIVED 11/7/17

2017