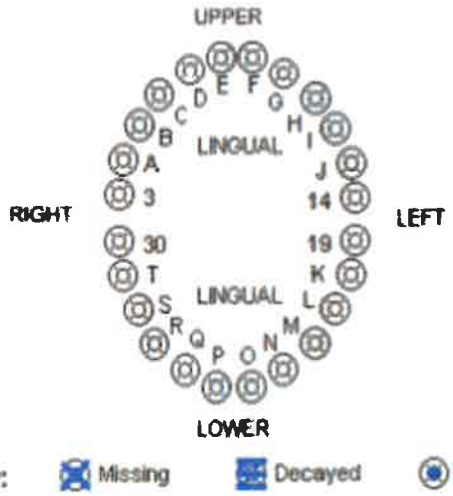
ENTERED 8D 11/17/16

LEADS Head Start/Early Head Start
Dental Exam

Child's Name: Kilo Schlattman Center: NC Date of Birth: 8/30/13

Parent's Name: Adam Schlattman **Date of Exam: 11/17/16**

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



Description of Work	Month	Day	Year
exam	11	17	16
x-ray	"	"	"
prophy	"	"	"
fluoride	"	"	"

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) Comfort Dental Heath Date: 11/17/16
613 Hebron Rd
Heath, OH 43056
740-788-8084

Provider Signature: _____ Phone: _____

Provider Address: _____