LEADS

LEADS Head Start/Early Head Start

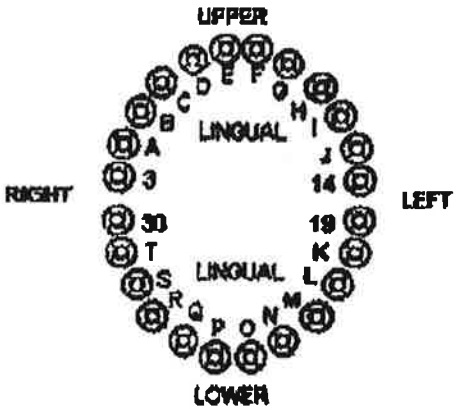
Dental Exam

Child's Name: Liara Gerber Date of Birth: 9/30/13

Parent's Name: Stephanie Skuias Date of Exam:

Center: EHS-LC/HB-LC Phone: 740-345-7586 Fax: 740-345-4303

ORAL CONDITION: Before Treatment (using key)



Key: Missing Decayed Filled

Description of Work	Month	Day	Year
Child Prophy	11	2	17
2 occl.	11	2	17
F1	11	2	17

Indicate restorations.

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
(X) Routine recall visit due 5-3-18
( ) Recommend fluoride supplement _____
(X) Is this child up to date on scheduled age appropriate preventive care [please circle] YES NO
( ) Other _____

Name of Provider: (please print) Dr. Marc Lewis Date: 11-14-17

Provider Signature: Marc Lewis, D.D.S. Phone: 7403480161

Provider Address: 1091 W. Main St Newark OH 43055

2017

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

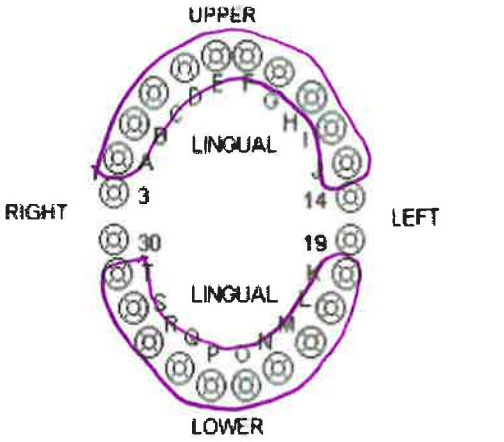
LEADS Head Start/Early Head Start
Dental Exam fax- 740-345-4303

ENTERED

Child's Name: Liara Better Center: _____ Date of Birth: 9/30/2013

Parent's Name: _____ Date of Exam: 9/14/2016

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



Key: Missing Decayed Filled

Description of Work	Month	Day	Year
child present Ex F	9	14	2016

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
( ) Routine recall visit due in 6 months
( ) Recommend fluoride supplement No
( ) Is this child up to date on scheduled age appropriate preventive care [please circle] YES NO
( ) Other Looks great!

Name of Provider: (please print) Newark Family Dentistry Date: 9 14 2016

Provider Signature: _____ Phone: 740 349 3033

Provider Address: 136 W Main St Newark 43055