Prairie Five Head Start Dental Health Record

Child's Name (Patient): _____ Date of Birth: _____

Parent/Guardian Name _____ Phone Number_____

This child's dental examination should be billed to:

☐ *Dental Insurance* ☐ *Medical Assistance* ☐ *Prairie Five CAC* **(with PRIOR APPROVAL)**

DATE OF SERVICE: _____

SERVICES PROVIDED	***CHECK ALL THAT APPLY***	***PLEASE CHECK ONE OF THE FOLLOWING:***
EXAMINATION		_____ Exam completed, no treatment needed.
PROPHYLAXIS		
FLUORIDE VARNISH/TREATMENT		_____ Exam and treatment completed today. (Complete Follow Up Treatment Needs section)
X-RAYS		
EMERGENCY TREATMENT		_____ Exam and further dental treatment is needed, (Complete Follow Up Treatment Needs section)
ORAL HYGIENE INSTRUCTION		
OTHER		_____ Patient referred; please list where: _____.

FOLLOW UP TREATMENT NEEDS (only complete if treatment is needed or was done):

√ If urgent need	***Tooth # or Letter***	***Description of Recommended Dental Services***	***Appointment dates***	***Completed YES/NO***

All dental treatment completed: _____ Yes _____ No

More appointments needed for treatment? _____ Yes _____ No

If yes: Next appointment date: _____/_____/_____

_____ _____ _____

Dental Provider (Please Print) **Signature** **Date**

_____ _____ _____

Name of Dental Office **Phone Number** **FAX Number**

Please mail or fax the completed form to:

Prairie Five Head Start
P.O Box 166
Madison, MN 56256
Phone: 320-598-3118
Fax: 844-273-2299

45 CFR 1302.42
Updated on 5/2019

HC: _____ CP: _____ HS Center: _____ Date entered into ChildPlus: _____