Dental Exam Record

Child's Name: _____ **DOB:** _____

Billed To: □ Dental Insurance □ Medical Assistance □ Healthy Steps □ Caring Program
□ In-Kind □ Parent □ Other

A. **Verification**

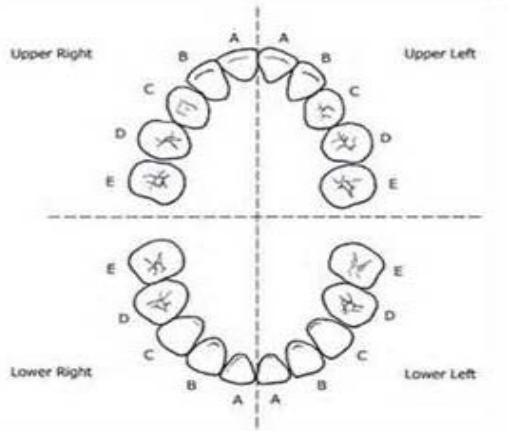
Date of most recent visit: _____

B. **Oral Conditions Before Treatment**

The following applies to this patient *(check all that apply)*:

□ Dental Exam Complete
□ Needs no treatment at this time
□ Treatment complete Date:_____
□ Needs routine examination Month:_____
□ Needs dental services listed in Section C below

Mark teeth: Missing: x Decayed: ϟ Filled: •



C. **Examination & Treatment Record:**

Tooth #	Surfaces	Description	Treatment Approved	Date Performed	Fee
Comments:				**Next Exam Date:**	

Dentist Signature: _____ **Date:** _____

Practice Name: _____ **Phone #:** _____

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