Chugachmiut Birth to Five Head Start
4000 Old Seward Hwy. Suite 203
Anchorage, AK 99503
Direct Line: (907) 248-5006

Dental Examination Report

CHILD'S NAME: _____ **SEX:** _____ **BIRTH DATE:** ____/____/____ **AGE:**_____

PARENT(S) NAME: _____ **PHONE NUMBER:** _____

HEAD START SITE: _____

Diagnostic and Preventive Procedures Performed:

- ❑ Clinical Examination
- ❑ X-Rays
- ❑ Fluoride Varnish Application-FV
- ❑ Prophylaxis
- ❑ Other

Recommendation of FV Applications Per/Yr ❑ **1** ❑ **2** ❑ **3**

Current Status:

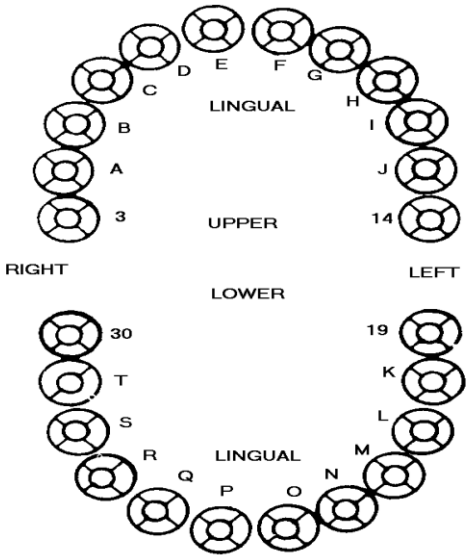
Cavities: _____**(How Many)** **Recurrent decay around old fillings:** _____ **(How Many)**

Gums and supporting tissues:
- ❑ Normal & Healthy
- ❑ Slight Inflammation (gingivitis)
- ❑ Moderate Inflammation (gingivitis)

Other: _____

Recommendation:

- ❑ No further recommended treatment at this time. Return in _____ months for an examination.
- ❑ Additional dental treatment is required. Treatment plan is identified below.



Tooth # or letter	Description of Dental Services Required

_____ _____ _____
Dentist Name (Please Print) Signature Date

_____ _____
Address, City, State & Zip Code Phone No.