GCCARD HEAD START PROGRAM

711 N. Saginaw Street, Suite 206, Flint MI 48503

Phone: (810) 235-5613 Fax: (810) 341-5852

DENTAL EXAM

CHILD'S NAME: _____ **DOB: _____**

PARENT'S NAME: _____ **DISTRICT: _____**

Dental Care Provider's Information:

Dentist Name: _____ **Dental Office: _____**

Phone #: _____ **Fax Number: _____**

Address: _____

Date of Exam: _____

RESULTS OF CHILD'S EXAM		
	YES	NO
EXAM		
BIGHTWING X-RAYS		
OTHER X-RAYS		
PROPHY		
SCREENINGS		
FLUORIDE VARNISH		
TREATMENT NEEDED		
TREATMENT COMPLETED		

TREATMENT SCHEDULED DATE: _____

TYPE OF TREATMENT NEEDED: _____

_____

_____

_____ _____

D.D.S / R.D.H SIGNATURE **DATE**

Approved hab-11-14-24