CENTRAL MISSISSIPPI, INCORPORATED

Head Start Program
101 South Central Avenue
P. O. Box 749
Winona, MS 38967

Phone: (662)283-2227
Fax: (662)283-5777

Head Start Dental Exam/Treatment Record

I. Child Information (Completed by Head Start Staff)

Child's Name ______________________ Sex ___ Birthdate ________ Home Phone ____________

Parent's Name ______________________ Home Address ______________________

Head Start Center ______________________ Classroom ______________________

Source of Payment ☐Medicaid # ______________ ☐Head Start ☐Other __________ Group # __________

Medical Alert: ____

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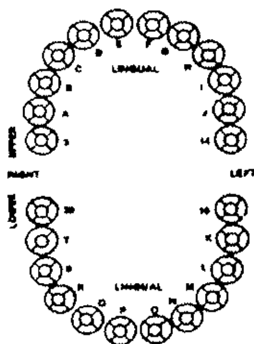
II. Exam (Completed by Dentist) Name of Dentist ______________________ Phone Number ______________

A. Existing Condition

Red=Decay Blue=Filling X=Missing



B. Proposed Treatment (Indicate approximate numbers if possible)

___ Fillings Number of Appointments _____

___ Crowns

___ Pulp Treatments

___ Extractions Approximate Cost __________

___ Other ______________________

Comments ______________________

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____

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Date of Exam ______________

Signature of Dentist ______________________

III. Treatment (Completed by dentist as treatment progresses)

Date	Treatment	Fee

Date	Treatment	Fee

Comments ______________________ Total Charges ______________

IV. (Completed by dentist at final visit)

I certify that I have completed the above services and that the child has received all necessary treatment as requested by the Head Start Program.

Signature of Dentist ______________________ Date ______________