PRIVATE DENTIST DENTAL EXAMINATION FORM

NAME OF CHILD:			
	LAST	FIRST	DATE OF BIRTH
NAME OF SCHOOL:		CLASS:	
ADDRESS:			.
	STREET	CITY	ZIP
TREATMENT CON	ИPLETED:	YES: NO:	
CHILD UNDER TR	EATMENT—the followi	ing is still needed:	
0	X-rays		
0	Cleaning		
0	Fluoride / Sealant Ap	pplication	
0	0-		
0			
0	Other:		
DATE OF DENTAL	. EXAM:	DATE OF NEXT EXAM:	
PRINT NAME OF	DENTAL EXAMINER:		
SIGNATURE OF D	ENTAL EXAMINER:		
ADDRESS:			
PHONE:			

CAPITAL AREA HEAD START: 3705 ELMWOOD DRIVE, HBG PA 17110 PHONE (717) 541-1795 / FAX: (717) 541- 8226