Kalamazoo RESA Head Start/GSRP

RECORD OF DENTAL SERVICES

Child's Name: _____ Date of Birth: _____

Provider Name: _____ Phone Number: _____

A. EXAMINATION AND TREATMENT RECORD:

Service	Findings	Date of Service Month	Day	Year
Examination				
Prophylaxis				
Fluoride				
Sealant				
Treatment				
Treatment				
Treatment				

B. CHILD ORAL HEALTH SUMMARY:

All planned treatment is: ☐ Complete ☐ Not Complete

If not complete, please explain: _____

_____

Approximately how many visits will it take to complete treatment? _____

Referred To: _____

Next Appointment(s) Scheduled for: __/__/__; __/__/__; __/__/__

I certify that I have completed the service(s) listed above.

_____ _____

(Dentist Signature) **(Date)**

KALAMAZOO RESA Head Start

Great Start Readiness Program
Michigan's Nationally Recognized Pre-K Program

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