Adams County Head Start
Dental Treatment Form

PARENT(S), PLEASE COMPLETE:

Child’s Name: __________________________ Date of Birth: ______________
Head Start Center: __________________________ Phone: __________________

Cost of Dental Services Covered By:

☐ Medicaid ☐ Private Dental Insurance: __________________________
☐ CHP+ ☐ Federal, State, Local Agency: __________________________
☐ Head Start ☐ Other: __________________________
☐ Parents/Guardians Self-Pay

**TO BE COMPLETED BY DENTAL OFFICE ONLY**

Please fax completed form to ACHS Health Department at 720-523-7992

Priority Level:

☐ (1) Needs Immediate Attention ☐ (2) Needs Attention Soon ☐ (3) Needs Routine Care

Professional Dental Services and Treatment Provided (check all that apply):

☐ Dental Examination / Date: ___________ ☐ Sealants / Date: ___________ ☐ Oral Hygiene Instructions ___________
☐ X-Rays / Date: ___________ ☐ Fillings / Date: ___________ ☐ Cleaning/Prophylaxis / Date: ___________
☐ Extractions / Date: ___________ ☐ Fluoride / Date: ___________ ☐ Crowns / Date: ___________
☐ Parent Received Dental Ed / Date: ___________

☐ Routine Recall Visits ☐ Dietary Problems ☐ Needs Fluoride Supplement
☐ Developmental Problems ☐ Harmful Oral Habits ☐ Other/Explain:

Notes/Comments:

Child Oral Health Summary:

Has all treatment been completed? ☐ Yes ☐ No
If treatment is not complete, please briefly explain treatment plan including number of remaining visits:

OFFICE STAMP – If no stamp, please include:

Clinic Name: __________________________ Address: __________________________
Phone Number: __________________________ Date of NEXT VISIT: __________________________

If treatment is still needed

Dental Provider Signature: __________________________ Signature Date: ___________

Revised 04/18