PA Pre-K Counts-Duck Hollow Discovery Learning Center

7822 National Pike Uniontown, PA 15401 office: 724-438-6123

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Child Dental Assessment

Child NameAddress		Center			
A. List a report of the child's: 1. EXAM 2. PROPHY 3. FLUORIDE B. Check form of Payment: EPSDT Medicaid Parent Other C. The dentist's signature is required.* D. Please make us aware of follow-up appointments that are needed or if treatment is complete. E. Complete items 1-3.					
ORAL CONDITIONS BEFORE EXAMINATION AND TREATMENT RECORD (List recommended services in order) TREATMENT: missing (), decayed (), or filled () Indicate restorations you performed in Item 1.					
UPPER		Tooth or Letter	Description of work	Date Service Performed	
(S) C F G (S)	łΤ				- - - -
ST LINGUAL LO S LINGUAL LO P N MO SSSS LOWER					- - - -
🌠 Missing 🧮 Decayed 🬘) Filled				
3. DENTAL NEEDS (Check one or more) A. TREATMENT (restoration, D B. CLEANING C. FLOURIDE					
pulp therapy, extraction) D. OTHER		PROBLEMS	— C.11200	MDL	
Approximate number of visits Approximate cost					
4. CHILD ORAL HEALTH SUMMARY All planned treatment (is is not) complete. If not, explain here as well as items checked					
a. Routine recall visits b. Special home emphasis, oral hygiene		ary problem(s		e. Harmful oral hab	 pits
I certify that I have completed the service(s) listed Signature Printed Name of Dentist	Date				