Watervliet Jr. Cannoneers

Albany Community Action Partnership

Dental Examination Report

FAX: 629-3250

albany community action partnership

THE POWER OF CHANGE

CHILD'S NAME: _____ SEX: ____ BIRTH DATE: ____/____/____

PARENT(S) NAME: _____ PHONE NUMBER: _____

HEAD START/UPK SITE CHILD WILL ATTEND: _____

I AGREE TO HAVE THIS INFORMATION RELEASED TO ACAP HEAD START- Parent Signature _____

****** **DATE OF EXAM-** _____ ********

Diagnostic and Preventive Procedures Performed:

- ☐ Clinical Examination
- ☐ X-Rays
- ☐ Prophylaxis
- ☐ Fluoride application
- ☐ **Other** _____

Current Status:

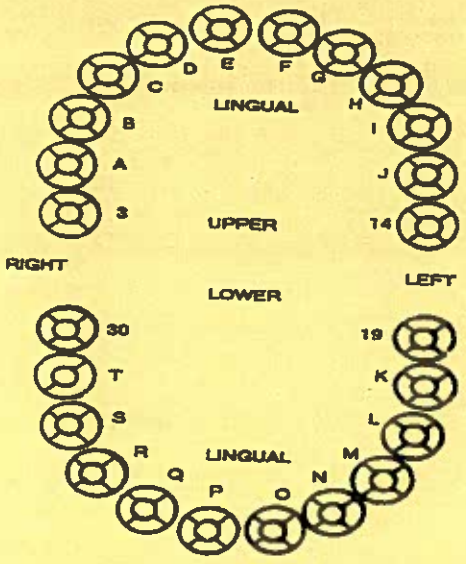
Cavities: _____ (How Many) **Recurrent decay around old fillings:** _____ (How Many)

Gums and supporting tissues: ☐ Normal & Healthy ☐ Slight Inflammation (gingivitis) ☐ Moderate Inflammation (gingivitis) ☐ Advanced disease (periodontitis)

Fluoride: _____ Other: _____

Recommendation:

- ☐ No further treatment recommended at this time. Return in _____ months for an examination.
- ☐ Additional dental treatment is required. ☐ **Fluoride** _____



Tooth # or letter	Description of Dental Services Required	Date & Description of Services Rendered

FORM MUST BE SIGNED BY DENTIST: (*****Please enter **date of exam** at top of form*****)

_____ _____ _____

Dentist Name (Please Print) Signature Date of signature

_____ _____

Address, City, State & Zip Code Phone No.