Coastal Community Action, Inc.

Early Head Start / Head Start Program

303 McQueen Ave. Newport, NC 28570

Dental Examination Report

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

PARENT(S) NAME: _____ **PHONE NUMBER:** _____

INSURANCE NUMBER (MEDICAID OR PRIVATE INSURANCE): _____

CCA Child Development Center: _____

Diagnostic and Preventive Procedures Performed:

- ❑ Clinical Examination
- ❑ X-Rays
- ❑ Prophylaxis (cleaning)
- ❑ Fluoride application
- ❑ Screening only (age 0-2 only)
- ❑ Sealants

Current Status:

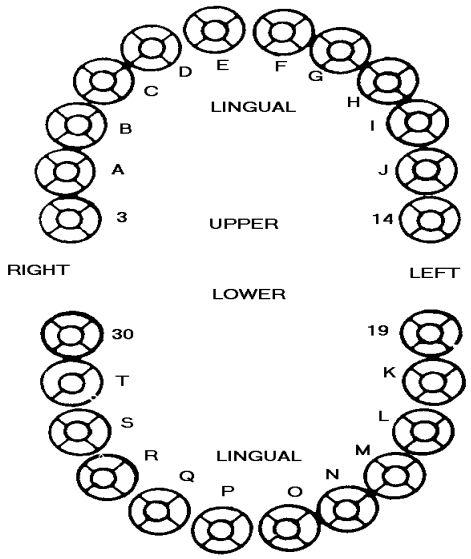
Cavities: _____ **(How Many)** **Recurrent decay around old fillings:** _____ **(How Many)**

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

Other: _____

Recommendation:

- ❑ No further treatment recommended at this time. **AND** Return in _____ months for an examination.
- ❑ Additional dental treatment is required. **AND** Treatment plan is identified below.



Tooth # or letter	Description of Dental Services Required

_____ _____ _____

Dentist Name (Please Print) Signature Date

_____ _____

Address, City, State & Zip Code Phone No.

Completed Forms should be returned to child's Child Development Center