



# HEAD START, INC.



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## WELL CHILD CHECK UP- DENTAL

<b>* Child's Name:</b>		<b>* DOB:</b>	<b>* Room #</b>
<b>* Dentist's Name/Business Address/Phone #: (please print)</b>			
<b>* Description of work done- Please describe services performed (e.g. initial exam, x-rays, cleaning, treatment, etc.)</b>			<b>* Date:</b>
<b>* Results and Recommendations:</b>			
<input type="checkbox"/> No problems <input type="checkbox"/> Cleaning/fluoride <input type="checkbox"/> Emphasize oral hygiene at home <input type="checkbox"/> Treatment needed: <i>(Please specify number of each type needed)</i> _____ sealants _____ restorations _____ pulp therapy _____ extractions _____ approximate total # of visits needed to complete treatment			
<b>* Excluding routine checkups, cleaning and fluoride, all treatment</b> <input type="checkbox"/> is <input type="checkbox"/> is not complete.			
<b>* Prescription given for fluoride?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>* Next scheduled appointment:</b>			
<b>* Other recommendations:</b>			
<b>Signature of Dentist</b>		<b>Date</b>	