EARLY CHILDHOOD PROGRAMS
DENTAL EXAM – Birth to 5 years

Name _____ **ID#** _____ **Staff #**_____

Has this child had previous dental care? Yes No

SERVICES PROVIDED:

Month	Day	Year	Description of Work

Needs to return for: Urgent Care _____ Appointment Date _____

Dental Work _____ Appointment Date _____

Routine Recall Exam at 6 months _____ at 1 year _____ Date _____

If examination was not completed, please indicate reason: _____

Dental health education provided: _____

_____ _____
Signature of Dentist Date

_____ _____
Address Phone

I hereby authorize my child's dental care providers and DMPS Early Childhood Programs to release to each other and exchange between each other information contained in the clinical records of _____. Redisclosure to any 3rd parties is prohibited without my written consent.

_____/_____ _____/_____
Signature of Parent/Legal Guardian Date Signature of Witness Date

_____/_____
Signature of Parent/Legal Guardian Date

Rev. 11/2007