

Child's Name: _____ DOB: _____ M ___ F ___ Center: _____

Parent/Guardian Name: _____ Phone: _____

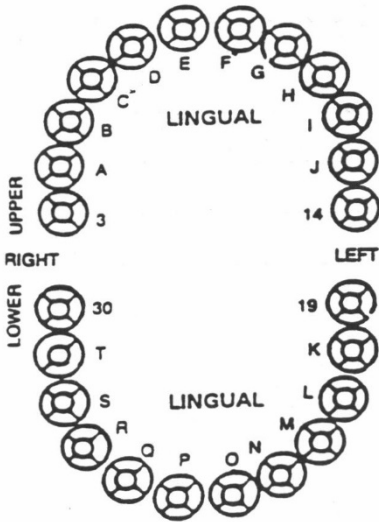
Address: _____

I authorize professionally qualified individuals to exchange information about my child. I understand that all information will be kept in a confidential file.

Parent/Guardian Signature _____ Date: _____

TREATMENT NEED SUMMARY

A. Please list recommended services in order on the table below and restoration(s) you performed:



Tooth # or letter	Surfaces	Description of services	Date of service

Cleaning and fluoride treatment date completed _____

B. In diagram above indicate, oral conditions **before treatment**: Missing  Decayed  Filled 

CHILD ORAL HEALTH SUMMARY

C. Dental Needs

Routine recall visits Special home emphasis, oral hygiene

D. Problems Noted

Dietary Harmful oral habits
 Developmental Other _____

E. All planned treatment:

Is complete Is not complete.

If treatment is not complete, please specify pending treatments; **Date of next appointment:** ____/____/____

Treatment (e.g. restoration, extraction) X-rays Cleaning Fluoride Sealant(s) Other _____

Please return completed forms to the parent/guardian or send to: SETA Head Start, 925 Del Paso Blvd., Suite 200, Sacramento, CA 95815. Phone: (916) 263-3804

Dentist _____ Signature _____

Date _____ Phone _____ Address _____