MATURA Head Start
Dental Exam Form

Must be performed & signed by a Dentist

Please return this form to:
MATURA Head Start
209 N. Elm St.
Creston, IA 50801
Ph: 641-782-6201
FAX: 641-782-6302

Child's Name: _____ Date of Birth: ____/____/____

Dentist's Name: _____ Phone: ____-____-_____ Fax: ____-____-____

Dentist's Address: _____

Dental History

1. Has child ever been examined or treated by a dentist? Name & Date _____ No ☐ Yes ☐
2. Has child ever complained about teeth____, gums____, mouth _____? .. .. No ☐ Yes ☐
3. Has child ever had a tooth pulled? ..... No ☐ Yes ☐
4. Has child ever had an accident involving the mouth? ..... No ☐ Yes ☐
5. Child is under a physician's care / regular medication (explain) ..... No ☐ Yes ☐
6. Child drinks fluoridated water (city or rural water) ☐, water that is filtered ☐, bottled water ☐, other ☐_____?

MATURA Head Start requests that dentists complete a dental examination, clean child's teeth, apply topical fluoride and x-rays if needed.

Examination and Treatment Record

Date of Service	Description of Work	Cost

Dental Needs

- ⌗ No Problems
- ⌗ Treatment Estimated Cost: _$_____
- ⌗ Referred to: _____

Child's Oral Health Summary

All planned treatment ☐ **is** ☐ **is not** complete. If not, please explain: _____

_____

Dentist's Signature _____ Date _____

I am the parent/guardian of the above-named child. I give permission to share this information with MATURA Head Start and/or associated school.

_____ _____ _____

Parent/Guardian Printed Name **Parent/Guardian** Legal Signature **Date**