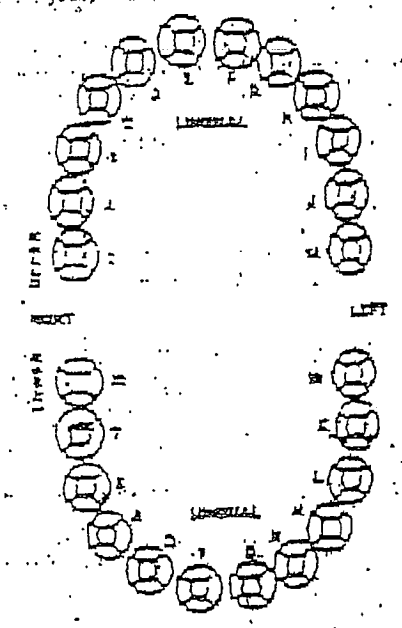
Muskingum County Head Start Program
and
Early Learning Initiative Program (E.L.I.)
DENTAL TREATMENT RECORD

Child's Name:_____ Date of Birth:_____
(Please Print)

Parent's Name:_____ Phone#:_____

Address:_____

ORAL CONDITIONS BEFORE TREATMENT:



Date	Tooth	Surface	Description of Work
	All	All	Examination, Prophy, X-rays ☐ Varnish ☐

HEAD START_____ OTHER_____

Please check appropriate space pertaining to this child

☐ Needs treatment (restoration, pulp therapy, extraction)

☐ No treatment needed at this time

☐ Treatment (other than routine exam) ☐ Is completed ☐ Is not completed

☐ Other, please specify_____

Dr. Signature:_____ Phone_____

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