Early Learning Program

DENTAL EXAMINATION/TREATMENT RECORD

Student's Name: _____ Birthdate: _____

To be completed by Dental Provider: Date of most recent Dental Exam: _____

Findings: (check and complete all those that apply)

Hygiene Appointments:

_____ Was in for an examination and prophy on _____

_____ Needs to schedule an examination and prophy

_____ Is scheduled for a 6 month examination and prophy on _____

Treatment Needs:

_____ No Treatment needed

_____ Treatment needed (restorative, pulp therapy, extractions)

_____ All treatment was completed on _____

_____ First phase of treatment completed on _____

_____ Has treatment appointment scheduled on _____

_____ Needs to schedule treatment

_____ Was a referral given for treatment? To Whom: _____

_____

Dental Clinic: _____ Phone: _____

Dental Provider Signature: _____ Date: _____

SEND COMPLETED FORM TO:

Prairie Ridge Early Learning School, 3031 Epiphany Lane, Eau Claire WI 54703

715-852-3630 **Fax #715-852-3604** **jpeck@ecasd.us**