GREEN HILLS HEAD START

Dental Examination & Diagnosis Form

Child's Name:	**Parent(s) Name:**
Birthdate:	**Address:**
Head Start Location:	
Medicaid/Private Insurance #:	**Phone Number(s):**

ATTENTION DENTAL PROFESSIONAL:

Head Start will pay **ONLY** if the child is **NOT ELIGIBLE** for Medicaid. A current denial of Medicaid from FSD must be on file before Head Start funds can be authorized for payment. You will receive a Record Treatment Form after the Examination and Diagnosis Form has been processed. If you have an emergency situation, please call (660)359-2214. Head Start, with *recommendation of the Health Advisory Committee,* has adopted the **current Medicaid reimbursement rate** for non-Medicaid children.

Oral Exam	**$24.00**	**Bite Wings**	**21.00**
Prophylaxis	**21.31**	**Fluoride**	**11.63**

Examination Date: _____/_____/_____ **Next Appointment: _____/_____/_____**

Check if Performed

Prophylaxis: _____

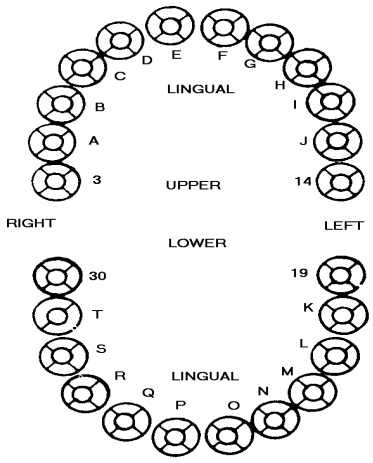
Diagnostic Radiographs: _____

Fluoride Treatment: _____

Priority Group

Needs Routine Care: _____

Needs Attention Soon: _____



Treatment Needed:

Tooth # or Letter	Description of Service

Dentist Name (Please Print) Signature Date

Mail to: Green Hills Head Start, 205 West 18th Street, Trenton, MO 64683 Phone: (660)359-2214 Fax: (660)359-5787