GREEN HILLS HEAD START
DENTAL HEALTH RECORD TREATMENT

For use when treatment is performed at a time subsequent to examination. Submit a completed form every 90 days on work completed during that 90-day period, if treatment is prolonged.

Child's Name: _____
(First) *(Last)*

Head Start Location: _____ Medicaid #: _____

PLEASE COMPLETE

Check if: **WORK COMPLETED**: _____

MORE WORK is planned: _____ Date of next appointment: _____

If work is **Discontinued**, check here: _____

Explain why below: _____

_____

TREATMENT PROVIDED

Please put each treatment on a separate line.

Date	Tooth #	Surface	Description of Work	Fee
			Total Fee:	

BILLED TO:

Parents ☐ Head Start ☐ Medicaid ☐

_____ _____ _____
Dentist's Signature *License #* *Date*

SEND COMPLETED FORM TO:

Dental Coordinator
Green Hills Head Start
PO Box 177
Trenton, MO 64683