Green Hills Head Start
DENTAL TREATMENT RECORD

Complete when treatment is performed at a time subsequent to examination.

CHILD INFORMATION

Child's Name:	Birthdate:
Head Start Location:	Medicaid/Private Insurance #:

PLEASE COMPLETE

Check if:

WORK COMPLETED: _____

MORE WORK IS PLANNED: _____ Date of next appointment: _____

WORK IS DISCONTINUED: _____ Explain why: _____

TREATMENT PROVIDED

Please put each treatment on a separate line.

Date	Tooth #	Surface	Description of Work	Fee
			Total Fee:	

BILL TO:

Parents ☐ Head Start ☐ Medicaid ☐

_____ _____ _____

Dentist's Signature License # Date

SEND COMPLETED FORM TO:

Health Specialist
Green Hills Head Start
PO Box 177
Trenton, MO 64683
Office: 660.359.2214 Fax: 660.359.5787