Child Development Resources
Helping Stars Shine Their Brightest!

Head Start/State Preschool Program
Dental Care Report

Head Start Center: _____ Class: _____

Dear Doctor _____,

Your Patient: _____ _____
Child's Name D.O.B.

is enrolled in the CDR Head Start/State Preschool Program. The child's parent/guardian has indicated that this child has been or is being seen in your office. Please confirm by completing this form and returning it back to us. Please check all that apply regarding the child's dental care. Thank you!

This Patient was Seen on: _____/_____/_____
Month Day Year

Patient Had the Following Procedure/s Done: Exam ☐ X-Rays ☐ Prophy ☐ FL ☐

Number of Cavities: _____ Treatment Provided Today: _____
(Ex: Pulpotomies, SSC, Fillings, Extractions, Etc.)

☐ No Further Treatment is Needed. Patient's Next 6 Month Dental Exam: _____/_____/_____
Month Day Year

☐ Patient is Under Treatment. Next Treatment Date is on: _____/_____/_____
Month Day Year

☐ Treatment was Completed on: _____/_____/_____
Month Day Year

☐ Patient was Uncooperative ☐ Patient was Referred to Dr. _____

_____ _____ _____
Dentist's Name (Please Print) Dentist's Signature Date

Thank you for your assistance!

Dentist Stamp/Phone

Family Services Specialist/Home-Based Teacher
Phone Number (805) -
Fax Number (805) -