Preschool Child Dental Treatment Form

Child's Name	Date of Birth:
Preschool Classroom site:	Gender: ☐ Male ☐ Female

Date of Dental Treatment: _____

- ☐ Treatment completed. Continue routine recall visits.
- ☐ Treatment requires more than one visit. Next visit scheduled for: _____
- ☐ Child is on waiting list for treatment appointment
- ☐ Child was referred to _____ for treatment

Provider Name (please print): _____ Provider Business Phone: _____

Provider Business Address: _____

Signature and Credentials of Provider: _____ Date: _____

Please return completed form to:

NICAO Head Start, 1190 Briarstone Drive, Mason City IA 50401 or fax to 641-494-1894

2/13/12, MS