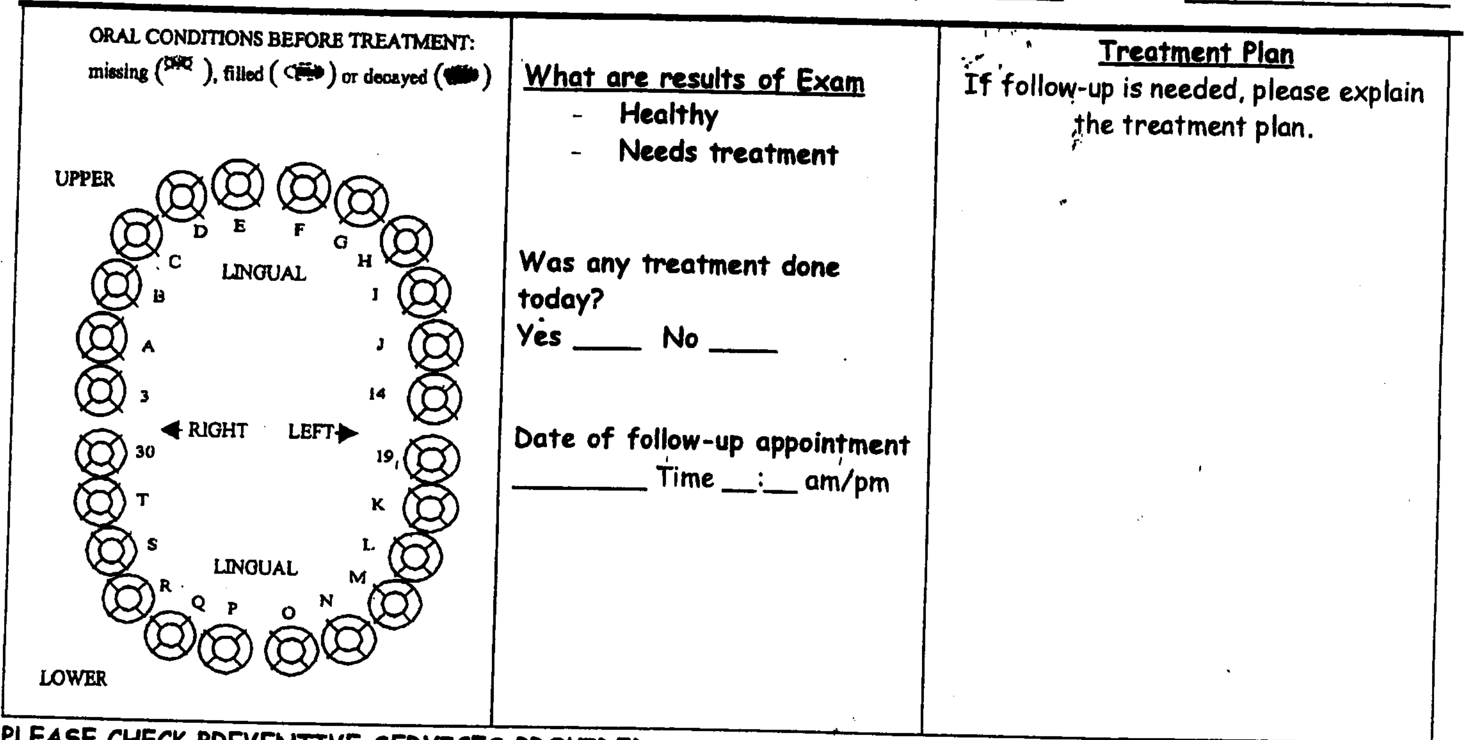
Cincinnati-Hamilton County
Community Action Agency
We help make things happen

Dental Form

Please return exam results to:
Cincinnati Public Schools
2120 Vine Street, Cincinnati, Ohio 45202
Telephone: 513-363-6580 Fax: 513-363-6585

Child's Name ______________________ Sex: ☐M ☐F D.O.B.__________
Parent/Guardian's Name ______________________ Phone __________
Address ______________________ Zip______ Center __________



ORAL CONDITIONS BEFORE TREATMENT: missing ( ), filled ( ) or decayed ( )

What are results of Exam
- Healthy
- Needs treatment

Was any treatment done today?
Yes _____ No _____

Date of follow-up appointment
________ Time __:__ am/pm

Treatment Plan
If follow-up is needed, please explain the treatment plan.

PLEASE CHECK PREVENTIVE SERVICES PROVIDED:
☐ Prophylaxis ☐ Fluoride ☐ Instruction in oral hygiene

TREATMENT SERVICES PROVIDED TODAY:
☐ Restorations ☐ Pulp Therapy ☐ Extractions ☐ Other

***IMPORTANT**: ☐ Check if all work for this child has been completed
☐ Check if additional work is required. Is this work urgent? Yes___ No___

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED

Date of Examination: ______________ Dentist Signature: ______________

Address: ______________________ Phone: __________ Fax: __________

Original Copy to: Head Start Program; Copy: Parent
CDHS- Health and Safety

Verline Dotson 3/2011
Grantee Head Start Director

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