Semcac Head Start
204 South Elm, PO Box 549, Rushford, MN 55971-0549
Phone: 507-864-7741 Fax: 507-864-2440
Visit: www.semcac.org
Email: heather.olloff@semcac.org

Semcac Head Start Birth to Age 5

This Institution is an Equal Opportunity Provider

DENTAL HEALTH RECORD

PATIENT'S NAME: ______________________________ BIRTH DATE: _____/_____/_____

ADDRESS: ______________________________ PHONE NUMBER________________________

PARENT/GUARDIAN: ______________________________

*I give permission for dental health records to be released to the Semcac Head Start program. This will expire 1 year from the date of signature.

PARENT OR ENROLLED ADULT SIGNATURE: ______________________________DATE___________________

DENTIST COMPLETE:

DATE OF SERVICE: ______________________________

SERVICES PROVIDED	***CHECK ALL THAT APPLY***
EXAMINATION/BSS	
PROPHYLAXIS	
FLUORIDE VARNISH	
X-RAYS	
EMERGENCY TREATMENT	
OHI	
OTHER	

PLEASE CHECK ONE OF THE FOLLOWING:

___ Exam completed, no treatment needed.
Return for a routine exam on ____/____/____.

___ Exam and treatment completed today.

___ Further dental treatment is needed,
(Complete Follow Up Treatment Needs section.)

___ Patient referred; please list where:
____.

FOLLOW UP TREATMENT NEEDS:

√ If urgent need	***Tooth # or Letter***	***Description of Recommended Dental Services***	***Appointment dates***	***Completed YES/NO***

All dental treatment completed: ____ Yes ____ No

More appointments needed for treatment? ____ Yes ____ No

If yes: Next appointment date: _____/_____/_____

If the patient is not covered by insurance, Head Start will assist families to find available resources to help pay for the exam and needed treatment. Head Start will only be responsible for payment of bills that have received prior authorization for payment.

<u>Please return this form to</u>: Semcac Head Start, P.O. Box 549, Rushford, MN 55971, FAX 507-864-2440 or <u>Email to</u>: heather.olloff@semcac.org

______________________________ ______________________________ ____________________
Dental Provider (Please Print) **Signature** **Date**

______________________________ ____________________ ____________________
Address, City, State, & Zip Code **Phone Number** **FAX Number**

Original – office HC_____ PA_____