**EARLY CHILDHOOD PROGRAMS**

**DENTAL EXAM – Birth to 5 years**

Name _______________________________ ID# ___________________ Staff #____________

Has this child had previous dental care?   Yes   No

**SERVICES PROVIDED:**

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<th>Month</th>
<th>Day</th>
<th>Year</th>
<th>Description of Work</th>
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Needs to return for:  Urgent Care _____ Appointment Date ______________

Dental Work _____ Appointment Date ______________

Routine Recall Exam at 6 months _____ at 1 year _____ Date __________

If examination was not completed, please indicate reason: ______________________________

Dental health education provided: ______________________________________________________

________________________________________ __________

Signature of Dentist          Date

________________________________________

Address          Phone

I hereby authorize my child’s dental care providers and DMPS Early Childhood Programs to release to each other and exchange between each other information contained in the clinical records of ___________________. Redisclosure to any 3rd parties is prohibited without my written consent.

________________________________________ ________________________/________

Signature of Parent/Legal Guardian Date Signature of Witness Date

________________________________________

Signature of Parent/Legal Guardian Date

Rev. 11/2007