HE62
Rev 6/17

L.B.J.& C. Head Start
Oral Health
Appointments and Follow-ups

Child's Name _____ **Date of Birth** _____/_____/_____

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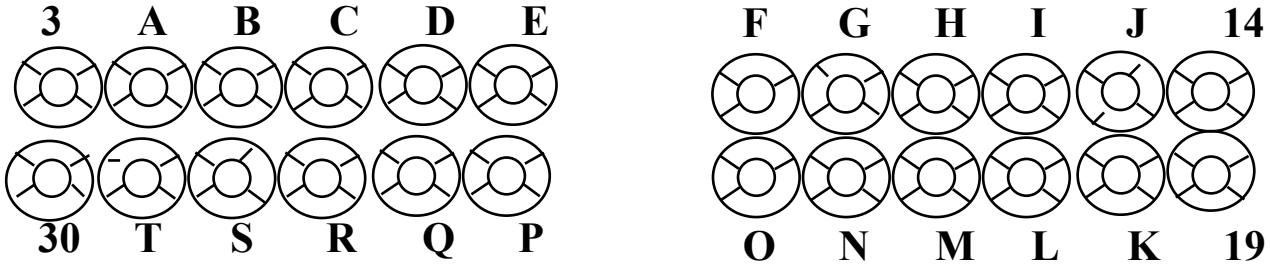
Services Provided

[ ] Exam [ ] Fluoride/cleaning [ ] Crown placement
[ ] Tooth/teeth pulled [ ] Cavities Filled [ ] Other: _____

Tooth # or Letter	Surface	Description of Services	Actual Charges

Total



Your child:

[ ] Needs no further treatment from the provider / 6 month recall only.
[ ] Will need additional treatment(s). Next Appointment: _____
[ ] Was referred and will need to see another provider.

I certify that I have completed the service(s) listed and that itemized charges do not exceed my usual and customary fees.

_____ _____
Dentist's Signature Date of Service

Dentist Office Name & Phone Number: _____

_____

White Copy: Parent **Yellow Copy: Child/Family Record**