CenClear

Dental Health Record - HTH - 16

Child's Name _____ ID# _____ Date _____
Childs D.O.B _____ Center/Program _____
Child's Home Visitor/Teacher _____

** **RETURN TO:** **CenClear**
PO Box 319
Bigler, PA 16825
(814) 342-5678

Fax Number:
(814) 342-2755
Attention: Health Department

Date of most recent visit _____

On this date child received: Exam ____ Cleaning ____ Fluoride Treatment ____ Uncooperative ____
(check all that apply)

Treatment at this time: ____ **IS** complete ____ **IS NOT** complete

Additional Treatment Needed: Next treatment appointment is: _____

Child referred to _____ for treatment

6 month recall appointment: _____

Comments:

Dental Care Provider: _____
Address: _____
Phone: _____

_____ Signature of Dentist

_____ Date