Please return this form to:
MATURA Head Start
209 N. Elm St.
Creston, IA 50801
Ph: 641-782-6201
FAX: 641-782-6302

MATURA Head Start
Dental Exam Form

Must be performed & signed by a Dentist

Method of Payment:
Medicaid _____
Insurance _____
Head Start _____

Child's Name _____ Date of Birth: ____/____/____

Dentist's Name _____ Phone: ____-____-_____ Fax: ____-____-_____

Dentist's Address: _____

Dental History

1. Has child ever been examined or treated by a dentist? Name & Date _____ No ☐ Yes ☐
2. Has child ever complained about teeth____, gums____, mouth _____? .. .. No ☐ Yes ☐
3. Has child ever had a tooth pulled? ..... No ☐ Yes ☐
4. Has child ever had an accident involving the mouth? ..... No ☐ Yes ☐
5. Child is under a physician's care / regular medication (explain) ..... No ☐ Yes ☐
6. Child drinks fluoridated water (city or rural water) ☐, water that is filtered ☐, bottled water ☐, other ☐_____?

MATURA Head Start requests that dentists complete a dental examination, clean child's teeth, apply topical fluoride and x-rays if needed.

Examination and Treatment Record

Date of Service	Description of Work	Cost

Head Start will pay up to $150.00 towards the exam and treatment if child has no insurance. Please bill Medicaid or private insurance first. Statements for service before November 30th must be received by December 16th.

Dental Needs

- ☐ No Problems
- ☐ Treatment Estimated Cost: _$_____
- ☐ Referred to: _____

Child's Oral Health Summary

All planned treatment ☐ **is** ☐ **is not** complete. If not, please explain: _____

_____

Dentist's Signature _____ Date _____

I am the parent/guardian of the above-named child. I give permission to share this information with MATURA Head Start and/or associated school.

_____ _____ _____

Parent/Guardian Printed Name **Parent/Guardian** Legal Signature **Date** (Valid for two years)