WILMINGTON CITY SCHOOLS

EARLY CHILDHOOD DENTAL FORM

Release: I give permission for my physician's office to fax/send this completed form to

Wilmington City Schools
Attn: Preschool Pupil Services
341 S Nelson Ave
Wilmington, OH 45177
Fax: (937) 382-1645

Child's name: _____ Date of Birth: _____
Parent's name: _____ Child's Age: _____
Address: _____ Date of Exam: _____
_____

Signature of Parent or legal guardian: _____ Date: _____

Is your child currently receiving any of the following fluoride?
___ Topical ___ Fluoridated Water ___ Fluoride Supplement diet (__tablets or __ liquid)

Does your child have any problems with teeth, gums, or mouth? ___ yes or ___ no

Has your child previously seen a dentist? ___ yes or ___ no
Name of Dentist seen: _____
Date seen: _____

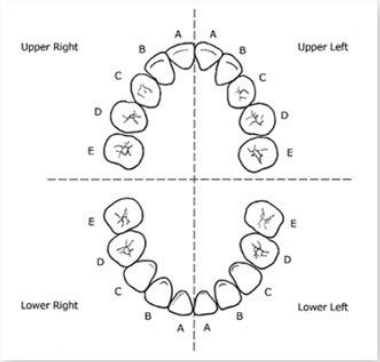
Does your child have a chronic condition that requires him/her to be under physician supervision?
___ yes or ___ no

Is your child currently receiving medication? ___ yes or ___ no
If yes, what type? _____

Child is reported to have (check all that apply):
___ Allergies ___ Asthma ___ Bleeding ___ Diabetes
___ Epilepsy ___ Liver Disease ___ Rheumatic Fever ___ Sickle Cell
___ Heart/Vascular Disease ___ Other_____

Source of reimbursement:
___ EPSDT/Medicaid ___ Federal, State, or Local Agency ___ Head Start
___ In-Kind Provider ___ Parent/Guardian ___ Other (Third Party Group)_____

Provider Use Only



Tooth	Surfaces	Description of Work	Date Services Performed (M/D/YY)	Proc #	Actual Charges

Dental Needs:

___ Treatment (restoration, pulp therapy, or extraction)
___ Cleaning
___ Fluoride
___ Other _____
___ No problems / Routing recall visits

I certify that I have completed the services listed and that itemized charges do not exceed my usual and customary fees.

_____ _____
Signature of Examiner Date

_____
Name of Examiner (please print)

Address: _____
_____
_____

Wilmington City Schools
341 S Nelson Ave
Wilmington, OH 45177
Phone: (937)382-1641
Fax: (937)382-1645