Washington State Department of CHILDREN, YOUTH & FAMILIES

Snohomish County ECEAP

Snohomish County

Dental Screening Form

Child's Name: _____ Birth Date: _____

Received a dental exam on: _____

Dental Services Included:

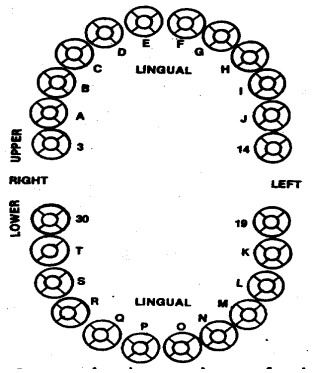
_____	Visual exam	_____	Prophylaxis	_____	X-rays: Not indicated
_____	Ride in chair and introduction to dental procedures	_____	Fluoride application	_____	Were taken
				_____	Treatment done (restoration, pulp therapy, extractions)

Exam Results Indicated:

_____	No problem	_____	Stronger emphasis on home oral hygiene	_____	Help with dietary problems
_____	Treatment needs (restoration, pulp therapy, extractions)	_____	Developmental problems	_____	Routine recall visit

Comments: _____

Treatment Plan:
Oral Conditions before Treatment:



Summarized Treatment Completed and Needs

Tooth # or Letter	Surfaces	Description of Work	Date Service Performed Mo	Day	Yr

Approximate number of visits needed to complete treatment: _____

Next appointment scheduled for: _____

Dentist's Signature: _____ Date Signed: _____

Clinic Name: _____

Address: _____ Telephone Number: _____

Please return this form to: Mukilteo ECEAP Preschool 3616 South Rd Ste.C4 Mukilteo, WA 98275
Phone:425-356-1312 Fax: 425-356-6684
Family Support Specialist: