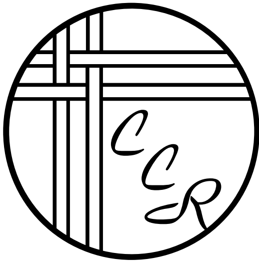

Community Care Resources, Inc.

Partnership in Planning

DENTAL EXAMINATION

Name of Youth:______________________________________ **Date of Birth:**______________

Date of Examination:___________________________ **Foster Parents:**___________________

Reason for Appointment: ☐ **Bi-Annual Check-Up / Cleaning** ☐ **Other**_________________

Dental Work Completed Today/Notes:____

____

____

____

Dental Work Needed/Recommendations (if any):____

____

____

____

Date Work Scheduled for:____

Next Appointment:

☐ **Bi-Annual Check-Up / Cleaning** **Date:**_____________________

☐ **Other**________________________ **Date:**_____________________

Signed____**,DDS** **Date:**_______________

Name of Clinic____

Address____

☐ ***Child is too young for Dental Exams outside of Pediatric Exams.***
Dental Exams should begin once child is _______ years old.
Physician Signature: ___________________________ Date:_______

AFTER EXAMINATION, PLEASE RETURN TO: ***COMMUNITY CARE RESOURCES, Inc.***

Form Updated 02/2018