Center_____

ID# _____

Medicaid # _____

DENTAL HEALTH RECORD

Name of Child (Last, First, Middle)

CLM Community Action Agency
Early Childhood Programs
524 Ashmun Street
Sault Ste. Marie, MI 49783
906-632-3363 Fax 906-632-4255

Patient's Address:

City State/Zip County

Birthdate Sex_____ Is water flouridated? ☐ No ☐ Yes

Previous Dental Care ☐ No ☐ Yes

RIGHT PRIMARY TEETH

A B C D E UPPER F G H I J

LINGUAL

T S R Q P LOWER O N M L K

PRIMARY TEETH LEFT V

PLACE AN "X" ON TEETH REQUIRING TREATMENT

SERVICES PROVIDED: (PLEASE RECORD EACH TREATMENT ON SEPARATE LINE)

INITIAL SCREENING AND TREATMENT

MONTH	DAY	YEAR	TOOTH	SURFACE	MATERIAL	DESCRIPTION OF WORK	FEE
						TOTAL	

This is NOT a Bill.

TREATMENT CODE: SURFACES: M–Mesial D–Distal O–Occlusal L–Lingual I–Incisal B–Buccal or Labal
MATERIALS: A–Amalgam S–Silicate P–Acrylic C–Steel Crown O–Other

ADDITIONAL TREATMENT NEEDED (DO NOT DATE UNTIL RENDERED)
SERVICES PROVIDED: (PLEASE RECORD EACH TREATMENT ON SEPARATE LINE)

TREATMENT

MONTH	DAY	YEAR	TOOTH	SURFACE	MATERIAL	DESCRIPTION OF WORK	FEE