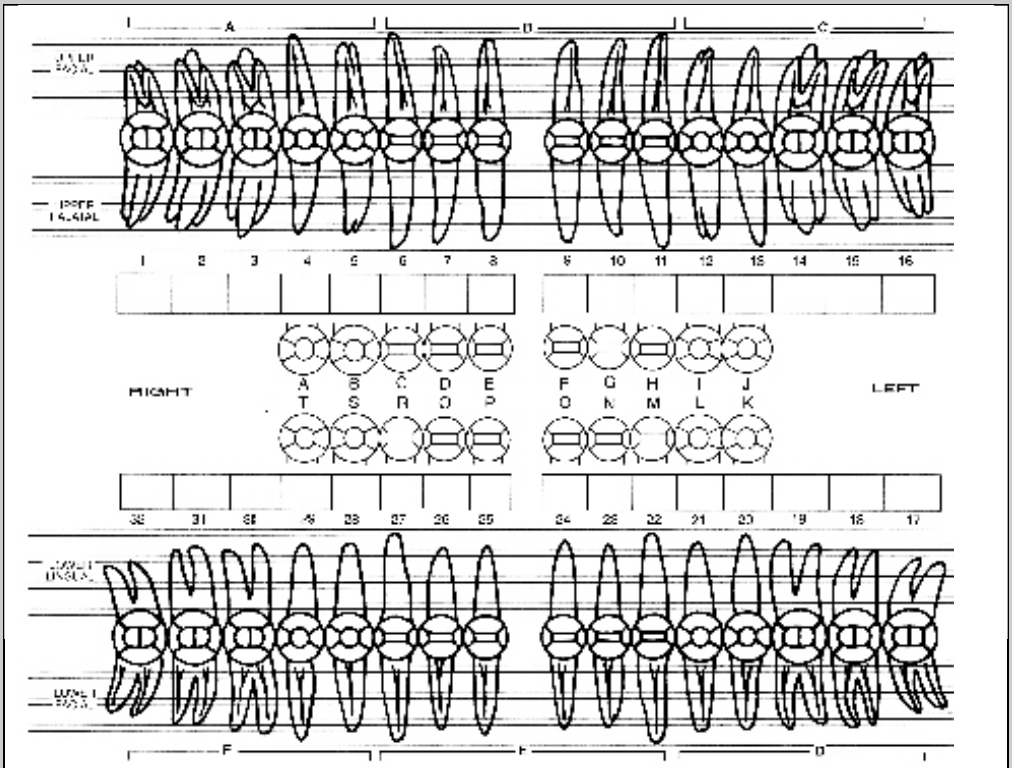
UMCHS - PRENATAL DENTAL EXAM RECORD

Patient's Name:_____ DOB:_____ Sex:_____

HS/EHS Center:_____ Insurance Provider:_____

HISTORY	ALLERGIES: MEDICATIONS:



REMARKS

DATE	TOOTH	TREATMENT PLAN	EST.	DATE	TOOTH	SERVICES RENDERED	FEE

DENTAL PROVIDER

Please complete the following information for Head Start.

(Check "✓" All Boxes that Apply.)

SERVICES COMPLETED

- ☐ Oral Hygiene Instruction
- ☐ Topical Fluoride & Prophy
- ☐ Sealants Applied
- ☐ Systemic Fluoride Prescribed

EXAM & TREATMENT SERVICES

- ☐ Normal Exam, Healthy
- ☐ Treatment Indicated:
  - ☐ Treatment In Progress, _____No. of Appts. Needed
  - ☐ Referred to:
- ☐ All Treatment Completed
- ☐ Return to Clinic:

BILLING INFORMATION

- ☐ Patient t Paid Out of Pocket
- ☐ Private Insurance
- ☐ OHP/Medicaid ☐ IHS/Tribal
- ☐ Head Start Voucher

Dentist Signature:_____ Phone:_____ Exam Date:_____

PLEASE RETURN EXAM RECORD TO UMCHS AT 110 NE 4TH STREET, HERMISTON, OR 97838
1-800-559-5878 – (541) 564-6878 – (541) 564-6879 FAX