HIGHLAND RIM HEAD START DENTAL TREATMENT PLAN

APPLICANT'S NAME	BIRTHDATE									
CENTER	PHONEPF					'ROGRAM: Head Start				
FAMILY SERVICE WORKER										
SOURCE OF REIMBURSEMI	ENT:									
TENN CAREHEAD S	TART	IN-KIND	PROVIDER	PRIVA1	TE IN	ISUI	RAN	CE DEDU	ICTIBLE AMOUNT	
I. COMPLETED BY DENTIST										
ORAL CONDITIONS BEFORE TREATMENT:	EXAMINATION AND TREATMENT			Treatment	1				ADA Procedure Actual Charges	
	or letter	Surfaces	of Work	Approved	performed			Number	(Fee)	
					MO	DY	YR			
FACIAL										
000000										
0^{5} 0^{2}										
$O_3 O_1 C_2 E_1 F_1 C_1 C_1 C_1 C_1 C_1 C_1 C_1 C_1 C_1 C$										
Q2 QB LINGUAL JO 150										
RIGHT RIGHT										
PERMANENT PRIMARY RIGHT NA										
LOWER										
$O_{32}O_T$ KO 10										
030 0 R N 190										
0^{29}_{28} 0^{20}_{20} 0^{20}_{21} 0^{20}_{22}										
FACIAL										
DENTAL NEEDS (Check	k one or r	nore and ret	urn to Head S	Start after exa	am).					
NO PROBLEMS	TRE	ATMENT						ALL TREATMENT	COMPLETE	
Examiner's Signature:						_ Date:				
Provider's Name:										
Provider's Address:				Provider's	s Fa	IX N	lum	ber:		
Provider's Signature:						_ Date:				
HS Approval Signature:						_ Date:				

MAIL FORMAL BILL TO: PO Box 208 Erin, TN 37061 Attn: Head Start (P) 931-289-4135 (F) 931-289-3220