HIGHLAND RIM HEAD START
DENTAL TREATMENT PLAN

I. COMPLETED BY FAMILY SERVICE WORKER

APPLICANT'S NAME ____ BIRTHDATE_______________

CENTER _________________________________ PHONE ______________________ PROGRAM: Head Start

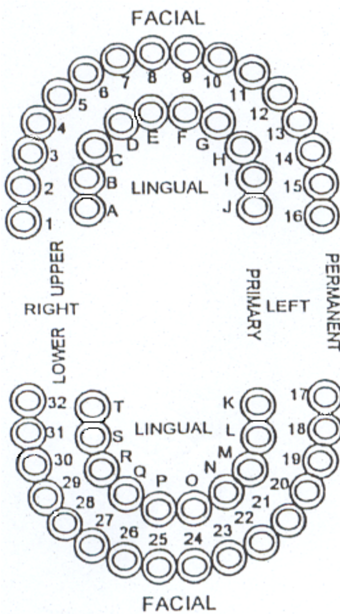
FAMILY SERVICE WORKER ____

SOURCE OF REIMBURSEMENT:

_____ TENN CARE _____HEAD START _____IN-KIND PROVIDER _____PRIVATE INSURANCE _________ DEDUCTIBLE AMOUNT

II. COMPLETED BY DENTIST

ORAL CONDITIONS BEFORE TREATMENT:



EXAMINATION AND TREATMENT RECORD (List recommended services in order).

Tooth # or letter	Surfaces	Description of Work	Treatment Approved	Date service performed			ADA Procedure Number	Actual Charges (Fee)
				MO	DY	YR		

DENTAL NEEDS **(Check one or more and return to Head Start after exam).**

________ NO PROBLEMS _______ TREATMENT ________ ALL TREATMENT COMPLETE

Examiner's Signature: ____ **Date:** ______________________________

Provider's Name: ________________________________ **Provider's Phone Number:** ______________________

Provider's Address: ______________________________ **Provider's Fax Number:** ________________________

Provider's Signature: ____ **Date:** ______________________________

HS Approval Signature: _______________________________________ **Date:** ______________________________

MAIL FORMAL BILL TO: PO Box 208 Erin, TN 37061
Attn: Sheena Lewis
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