Administrative Offices: 563.382.8436 / Fax: 563.382.9854 • Transit: 1.866.382.4259 / Fax: 563.382.4681

NORTHEAST IOWA COMMUNITY ACTION CORPORATION

305 Montgomery Street | PO Box 487 | Decorah, IA 52101

Dear Parent and Dental Provider,

Dental exams are **required** of each child enrolled in Head Start. ***Documentation of this exam is required within the first 45 days of enrollment and must be updated annually.***

Please bill Medicaid, HAWK-I, or any other primary/secondary insurance for services provided. *Head Start is to be the payer of last resort and can assist with payment if no other funds are available.* ***Please contact our office for pre-approval in this situation.***

Completed forms can be brought to Orientation, emailed to jada@neicac.org, faxed to (563) 382-9854, returned to your Family Service Specialist office, taken to the classroom, or mailed to Kallie at PO Box 487 Decorah.

We appreciate your cooperation. If you have any questions or concerns, please feel free to contact us at (563) 387-4938.

Kallie Moeller, RN, BSN
Health and Development Specialist
Northeast Iowa Community Action Corp.

Northeast Iowa Community Action- Head Start

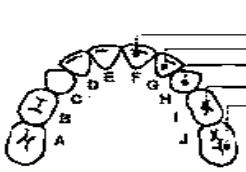
DENTAL EXAM

PO Box 487 Decorah, IA 52101
Phone: 563-382-8436 Fax: 563-382-9854

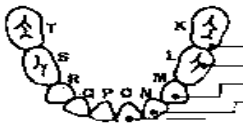
Date Exam Completed: _____

Child Name: _____

Oral Condition:



Upper Teeth	Erupt	Shed
Central Incisor	8-12 mos.	6-7 yrs.
Lateral Incisor	9-13 mos.	7-8 yrs.
Canine (Cuspid)	16-22 mos.	10-12 yrs.
First Molar	13-19 mos.	9-11 yrs.
Second Molar	25-33 mos.	10-12 yrs.



Lower Teeth	Erupt	Shed
Second Molar	23-31 mos.	10-12 yrs.
First Molar	14-18 mos.	9-11 yrs.
Canine (Cuspid)	17-23 mos.	9-12 yrs.
Lateral incisor	10-16 mos.	7-8 yrs.
Central incisor	6-10 mos.	6-7 yrs.

Comments

Flossing Frequency:

☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

Number of times per day child brushes _____

Gum Condition:

☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

Dental Needs:

☐ No Needs ☐ Treatment ☐ Cleaning ☐ Other: _____

Fluoride Varnish Completed at visit: ☐ Yes ☐ No

Treatment Plan

(Please complete this section if treatment is needed or has been completed)

Treatment completed ☐ Date completed: _____

Treatment scheduled ☐ Appointment date: _____

Treatment plan:

☐ Fillings ☐ Crowns ☐ Cleaning ☐ Braces ☐ Dentures ☐ Other: _____

Referral ☐ Dental clinic referred to: _____

Comments: _____

Provider Signature: _____ **Date:** _____

Print Provider's Name: _____

Dental Office: _____ **Phone Number:** _____