Oahe Child Development Center
P.O. Box 907
Pierre, SD 57501
224-6603

For Office use ONLY

_____EHS
_____HSHB
_____CB

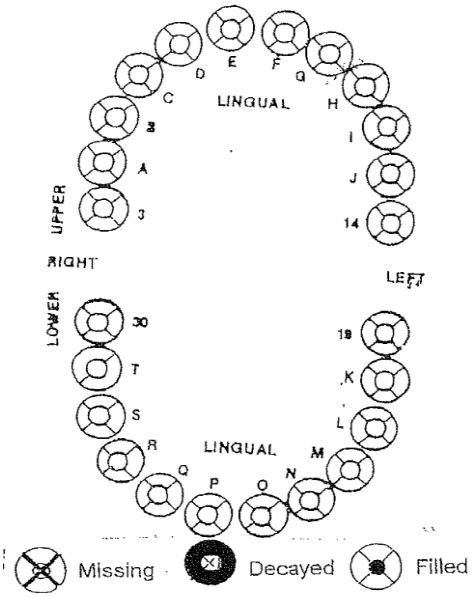
Dental Health

Date of Service:_____

Individual's Name:_____

Type of Service: ☐ Exam ☐ Treatment ☐ Prophylaxis

Oral Condition:



Tooth # or letter	Surfaces	Description of Work	Charge

Number of times per day individual brushes teeth:_____

Gum Condition:
☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

Dental Needs:
☐ No Needs ☐ Treatment
☐ Fluoride Supplement ☐ Cleaning/Fluoride Prophylaxis
☐ Other: Specify_____

Provider Office Please complete this section

Inkind Donation Today: $_____

Estimated Cost of Follow-up Treatment/Prophylaxis: $_____

Payment Source: ☐ EPSDT/Medicaid ☐ Inkind Donation: $_____ ☐ Parent
☐ Insurance ☐ Client requests Head Start assistance

Follow up appointment dates:_____

Comments:_____

Provider Signature:_____ Date:_____

Print Provider Name:_____