PROOF of DENTAL TREATMENT FORM
PACT, 2090 HWY 24, Camp Point, IL 62320

Child's Name _____ DOB ____/____ /____ Area # _____

_____
Address: Street City Zip Code Telephone

Parent/Guardian: _____

LIST DENTAL RESTORATIVE TREATMENT COMPLETED
or attach copy of office printout of treatment provided

Date of Treatment	Tooth #	Surface	Description

____ Additional treatment is still needed involving _____ teeth. Next TX appointment date(s) _____

____ No additional treatment is needed.

Remarks by dental provider for Head Start staff considerations: _____

_____

Dentist Signature _____ Date _____

Address _____ Ph. # _____
Street City Zip Code