NOCAC DENTAL FORM

LP-1102

Completed by Staff or Parent/Guardian prior to Exam

CHILD'S NAME ____________________ **BIRTH DATE**__________ **SEX** ________

PARENT/GUARDIAN ____________________ **PHONE** ____________

ADDRESS____________________ **CITY** ____________

****PARENT SIGNATURE ** Authorization to Release Form to NOCAC** ____________________

Is the child now receiving
Topical Fluoride Application Yes_____No____Unknown____
Fluoridated Water Yes_____No____Unknown____
Fluoride Supplement Diet: Yes_____No____Unknown____
(Tablets ☐ Liquid ☐) How long has fluoride been given? ____________

Does child have any trouble with teeth, gums, or mouth? ____________________
____

Has child previously seen a dentist? Yes_____No____Unknown____
Dentist's Name ____________________
Is child under a physician's care?
Yes_____No____Unknown____
Physician's Name ____________________
Is child currently taking medication? Yes_____No____Unknown_____
List any medication or any ongoing medical problems? ____________
____

Source of Reimbursement for service:

Medicaid # ____________________

Insurance # ____________________

Company Name ____________________

NOCAC child Development will pay up to $25 for exam $8 for bitewings for children not covered by above.

Oral Conditions Before Treatment:
Missing Decayed Filled
Indicate restorations performed in Box.

Examination/Treatment Record (List recommended services in order.)

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed M/D/Y	Actual Charges (Fee)

Completed by Dental Care Provider

COMPLETED: ☐ Exam ☐ Cleaning ☐ No Problem
☐ Fluoride ☐ Other ____________________

IS FURTHER TREATMENT NEEDED? ☐ Yes ☐ No Date of Next Appt. ____________

____

AREAS NEEDING ADDRESSED:

☐ Routine recall visit ☐ Dietary problem(s) ☐ Harmful oral habits
☐ Special home emphasis, oral hygiene ☐ Developmental problem(s) ☐ Needs fluoride supplement

I certify that I have completed the service(s) listed above and that itemized charges do not exceed my usual customary fees.

Dentist Signature ____________________ Exam Date ____________

Address ____________________ Phone # ____________

Return all copies if no treatment is needed
Retain "Pink copy" if treatment is needed and return when treatment is completed

Questions: Phone 419-784-2150
Fax 419-782-5648

*RETURN FORM TO: NOCAC CHILD DEVELOPMENT
ATTN: HEALTH MANAGER
1933 E SECOND STREET
DEFIANCE OH 43512

Rev 9/28/12

SAMPLE