BUTLER COUNTY EDUCATIONAL SERVICE CENTER
Early Childhood Programs
400 North Erie Blvd. Suite A
Hamilton, OH 45011
PH: (513)887-3716 Fax: (513)887-5539
www.bcesc.org

DENTAL FORM

Child's Name: ______________________________________Sex: ______ D.O.B: ____________

Parent/Guardian's Name: ______________________________________ Phone: ____________

Address: ____ Zip: ______ Center:_____________

Preventative Services Completed:
Date: ___________

____ Exam
____ Prophy
____ Fluoride
____ X-Rays
____ OHI

Treatment Completed:
Date: __________

____ Restorative
____ Extractions
____ Pulpotomy
____ Sealants

Comments: ____

- Check if treatment is required. How many restorations? ____
- Check if all services for this child have been completed
- Check if treatment is discontinued: Reason ____

6 month check up appointment: ______________ Next treatment date: ______________

I HEREBY CERTIFY THAT THE SERVICES LISTED ABOVE HAVE BEEN PERFORMED.

Dentist Signature: ____

Address: ____ Zip Code: ____________