Early Childhood Denial Form

Child's name________________________ Date of exam____________________________

Parent name_________________________ Address________________________________

Child's date of birth__________________ ______________________________________

RELEASE: I give permission for my dentist's office to fax this completed form to:
School: ______________________________ Fax: _________________________

Signature of Parent or Legal Guardian _____________________________________ Date ____________

Is child currently receiving any of the following fluoride? (Please circle)
Topical Fluoridated water Fluoride Supplement diet (tablets____ Liquid_____)

Does your child have any problems with teeth, gums, or mouth? Yes No

Has your child previously seen a dentist? Name________________ Last visit______________

Does your child have a chronic condition that requires him/her to be under physician supervision? Yes No

Is your child currently receiving medication? Yes No
If yes what type? _________________________

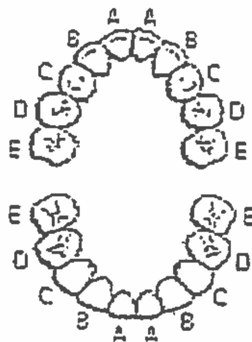
Child is reported to have (please circle)

Allergies Asthma Bleeding Diabetes
Epilepsy Liver Disease Rheumatic fever Sickle Cell
Heart/vascular Disease Other_________

Source of reimbursement: (Please Circle)

EPSDT/Medicaid Federal, State, or local Agency Head Start
Inkind Provider Parent/guardian Other (Third party group)______________

(Provider use only)



Tooth # Or Letter	Surfaces	Description of work	Date services perf. Mo	Day	Yr	Proc. #	Actual Charges	

Dental Needs: (Please circle)

Treatment (restoration, pulp therapy, or extraction) Cleaning Fluoride

Other________________________________ No problems/routine recall visits

I certify that I have completed the services listed and that itemized charges do not exceed my usual and customary fees

_________________________ __________________________ __________________
Address or Stamp of Examiner Signature of Examiner Date of signature