HIGHLAND RIM HEAD START DENTAL TREATMENT PLAN

I. COMPLETED BY FAMILY SERVI	CE WORI	KER								
APPLICANT'S NAME	BIRTHDATE									
CENTER			PROGRAM: Head Start							
FAMILY SERVICE WORKER										
SOURCE OF REIMBURSEM	IENT:									
TENN CAREHEAD S	START _	IN-KIND	PROVIDER .	PRIVA	TE IN	NSUF	RAN	CEDEDU	CTIBLE AMOUNT	
II. COMPLETED BY DENTIST										
ORAL CONDITIONS BEFORE	EXAMINATION AND TREATMENT RECORD (List recommended services in order).									
TREATMENT:	Tooth # or letter	Surfaces	Description of Work	Treatment Date service Approved performed			ADA Procedure Number	Actual Charges (Fee)		
	or letter		OI VVOIK	Approved	MO DY YR			Number	(ree)	
FACIAL										
60000a										
05 6000 120										
O3 OF F G JO 140										
O2 QB LINGUAL 1 150										
01 UA JU 160										
PER										
ANAWINA ANAMINA ANAWINA ANAMINA ANAMIN' ANAMIN										
LOWER AN										
©32										
031 08 LINGUAL L 0 180										
O 28 O O 21 O 21 O										
27 26 25 24 23 22 O										
FACIAL										
DENTAL NEEDS (Chec	ck one or	more and re	turn to Head	Start after ex	xam)).				
NO PROBLEMS	TRE	ATMENT						ALL TREATMENT	COMPLETE	
Examiner's Signature:				Date:						
Provider's Name:	Provider's Phone Number:									
Provider's Address:					Provider's Fax Number:					
Provider's Signature:		Date:								
HS Approval Signature:						Da	te:			

MAIL FORMAL BILL TO: PO Box 208 Erin, TN 37061 Attn: Head Start Telephone 931-289-4135 Fax 931-289-3220