# MAKE A WAY

**Make A Way, Child Placing Agency**
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## FOSTER CARE REPORT OF DENTAL EXAM

Date of exam/visit: _____ Age of Child: _____

Name of Child: _____ Date of Birth: _____

Diagnosis (please print):

Treatment(s) completed: Exam ____ X-Rays ____ Cleaning ____ Prophy ____ Fluoride ____
Fillings ____ Other ____ Return Appointment Needed _____

Referral to Another Provider? Yes No
Name: Specialty:
Address:

Telephone: Date to be seen:
Fax:

Was a complete dental exam performed during this visit? Yes No
Type of visit (circle): Routine Follow-up Ongoing Treatment
Other: _____

Name of clinic, including phone number (Please print or stamp).