Community Care Resources, Inc.

Partnership In Planning

DENTAL EXAMINATION

Name of Child _____ Date of Birth _____

Date of Examination_____

Foster Parents' Names _____
Address _____

Reason for Appointment _____
_____

Dental Work Needed _____
_____
_____

Special Problems Other Than Usual Restorations _____
_____
_____

Date Work Expected to be Completed _____

Recommendations, if any _____
_____
_____

Date of Next Dental Appointment _____

Signed _____DDS

Address _____
_____

Date _____

AFTER EXAMINATION, PLEASE RETURN TO: ***COMMUNITY CARE RESOURCES, Inc.***

6716 Stone Glen Drive • Middleton, WI 53562 • (608) 827-7100 • FAX (608) 827-7101

www.CommunityCareResources.com