DENTAL EXAM RESULTS LETTER
(For children identified as needing treatment)

Child's Name: _____

Does your child have dental insurance? _____ Yes _____ No

If "yes", what type of dental insurance? _____ TennCare

_____ Other private dental insurance

Please place a check mark below by the plan you wish to use to arrange for dental treatment for your child.

_____Plan A: I will make an appointment for my child to begin dental treatment.

_____Plan B: I would like the Family Partnership Assistant to schedule an appointment with a dentist to begin treatment for my child.

If you checked Plan A:

1.) What is the name of the dentist you have made the appointment with? _____

2.) What is the appointment date and time? _____

Parent comments: _____

_____ _____
Parent or Guardian Signature Date

Consent needed for children whose dental services will be paid for by Head Start

Regarding my child, _____ Date of birth _____
(Name of child)

I give permission for Head Start to obtain information from my child's dentist, Dr. _____, that is necessary for Head Start to have in Order to provide payment to the dentist for dental services provided. This information includes, but is not limited to, the treatment plan, estimated cost of treatment, payment expected/made by the child's dental insurance plan (if the child has dental insurance,) dates of service, and service provided.

_____ _____
Parent or Guardian Signature Date