DPP-106E
(R. 8/11)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services
DENTAL CARE

CHILD'S NAME: _____DOB: _____

DATE OF EXAMINATION: _____

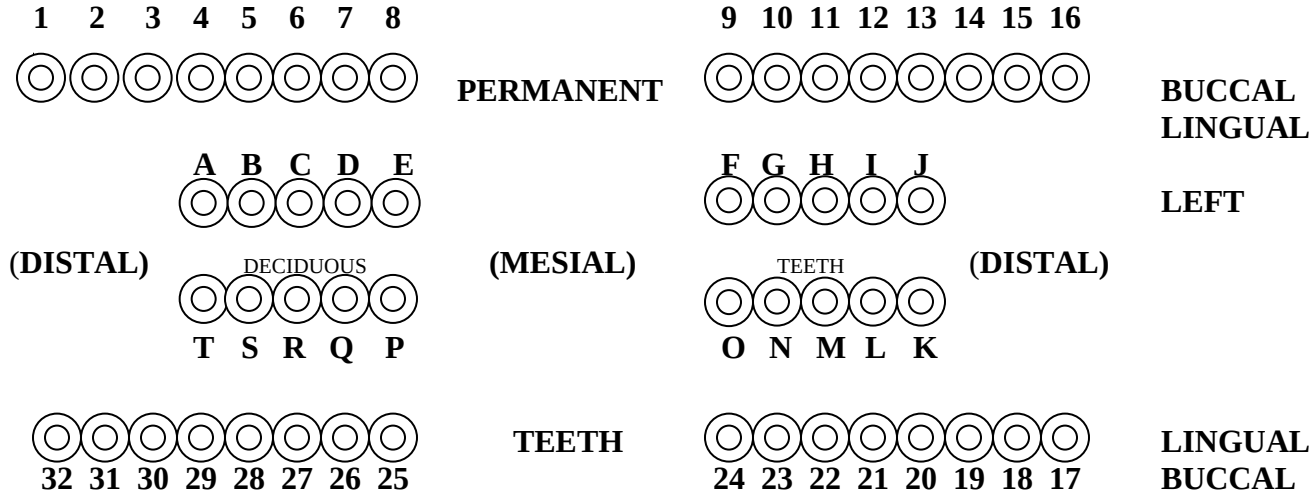
GENERAL APPEARANCE OF TEETH AND MOUTH: _____

_____

_____

_____

M: (missing) X: (extraction indicated)
BLUE color represents restoration present
RED color represents restoration needed



DOES CHILD NEED FOLLOW-UP APPOINTMENT? YES _____ NO _____

WHY?_____

_____

_____

_____

DATE OF CHILD'S NEXT APPOINTMENT: _____

DENTIST'S SIGNATURE _____
ADDRESS: _____
_____
PHONE _____

File Original, Passport Folder
Copy, Professional Section