EARLY CHILDHOOD EDUCATION AND ASSISTANCE PROGRAM
DENTAL ASSESSMENT FORM

ROOM _____ ☐ MW ☐ TTH

Child's Name _____ (LAST / FIRST / MI) Birth Date __ - __ - __ (MM DD YY)

Exam Date __ - __ - __ (MM DD YY)

PLEASE COMPLETE THE FOLLOWING REQUIRED ECEAP DATA AND SIGN THE RELEASE OF INFORMATION

PARENT

I GIVE MY PERMISSION FOR AN EXCHANGE OF INFORMATION REGARDING MY CHILD WITH THE FOLLOWING PROVIDER

PARENT SIGNATURE _____ DATE _____

PROVIDER'S NAME _____ PHONE __ - __ - __

PROVIDER'S ADDRESS _____ FAX __ - __ - __

PROVIDER

DENTAL SERVICE INCLUDED

- ☐ Visual Exam
- ☐ Prophylaxis
- ☐ X-Rays
- ☐ Fluoride Application
- ☐ Introduction to dental procedures
- ☐ Treatment done (restoration, pulp therapy, extraction)

Comments _____

EXAM RESULTS INDICATED

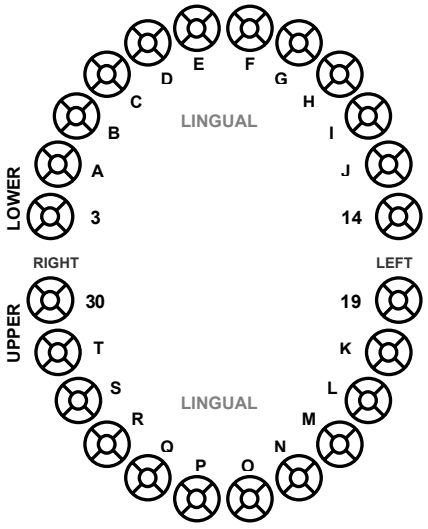
- ☐ No Problem
- ☐ Stronger Emphasis on Home Oral Hygiene
- ☐ Help w/ Dietary Problems
- ☐ Treatment Needs (restoration, pulp therapy, extraction)
- ☐ Developmental Problems
- ☐ Routine Recall Visit

Comments _____

TREATMENT PLAN

Condition before treatment

Missing ⊗ Decayed ⊗ Filled ⊗



Number of visits needed to complete TX _____

Next Scheduled Appointment _____

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF WORK	SERVICE PREFORMED		

PROVIDER'S SIGNATURE _____ **Signature Date** __ - __ - __

PLEASE RETURN COMPLETED FORM TO: Early Childhood Education and Assistance Program
1625 Madison Way * Lynnwood, WA 98087

If you have any questions, Contact _____ at (425) **356-1312** ext. _____ **FAX:** (425) **710-4448**