COLLEGE OF SOUTHERN IDHAO
HEAD START/EARLY HEAD START
998 Washington St. N.
P.O. Box 1238
Twin Falls, Idaho 83303-1238
(208)-736-0741

Appointment Date: ___/___/___ Child's Name: _____ Date of Birth: _____

Head Start Center _____ Head Start Tracking # _____ Medicaid # _____

Early Head Start Center _____ Early Head Start Tracking # _____ Medicaid # _____

Dear Dr. _____

Head Start/Early Head Start Requires a dental exam of every child enrolled in the Head Start program.

We understand _____ will be having this exam completed by your office.

Please compete a dental exam using the form attached, and return to the Head Start/Early Head Start Center whose address is indicated at the bottom of the page. If this child needs dental treatment, please provide the information needed, along with cost estimates.

Dental Treatment must be Pre-authorized and have a Tracking Number in order for Head Start/Early Head Start to cover dental follow-up treatment services.

Sincerely,

Family Educator

Please return Dental Exam form to the Head Start/Early Head Start Center indicated below:

Head Start/Early Head Start

_____
Center Name

_____
Center Mailing Address

_____
City/State/Zip code

Center Fax Number: __(208)_____