

TRY-AGAIN HOMES INCORPORATED
CHILD'S INITIAL AND PERIODICAL DENTAL EXAMINATIONS

THIS EXAMINATION IS REQUESTED BY TRY-AGAIN HOMES INCORPORATED TO DETERMINE THE HEALTH OF THE CHILD IN RESPECT TO PLACEMENT IN A FOSTER HOME.

CHILD'S NAME: _____

BIRTHDATE: _____

DATE OF EXAMINATION: _____

RECOMMENDATIONS: _____

DENTIST'S NAME AND ADDRESS: _____
(PLEASE PRINT)

(DENTIST'S SIGNATURE/DATE)

PLEASE FORWARD COMPLETED FORM TO:

TRY-AGAIN HOMES INCORPORATED
1800 LOCUST AVENUE
FAIRMONT, WV 26554

TRY-AGAIN HOMES INCORPORATED
DENTAL FOLLOW UP FORM

CHILD'S NAME: _____

DATES OF PAST APPOINTMENTS AND WORK THAT HAS BEEN COMPLETED:

DATE: _____ WORK COMPLETED: _____

DATE: _____ WORK COMPLETED: _____

DATE: _____ WORK COMPLETED: _____

THE ABOVE NAMED CHILD IS NOW IN GOOD DENTAL HEALTH AND SHOULD RETURN TO THIS OFFICE FOR A RE-EXAMINATION ON _____.

DENTIST'S SIGNATURE: _____

FURTHER COMMENTS: _____
