DENTAL TRACKING SHEET

Center _____

Classroom_____

MC - Medicaid
C - Complete
W - Work

Child's Name	MC Y or N	Date of Initial Dental Appt.	Results		1st Appt.			2nd Appt.			3rd Appt.			4th Appt.			Dentist's Name
			C	W	Date	C	W	Date	C	W	Date	C	W	Date	C	W	

Rev 12/23