TRY-AGAIN HOMES, INC.

CHILD’S INITIAL AND PERIODICAL DENTAL EXAMINATION

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:

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DENTISTS’S CONTACT INFORMATION:

NAME: ____

ADDRESS: ____

____

TELEPHONE/FAX: (   ) _________________   (   ) _____________________

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(DENTIST’S SIGNATURE/DATE)

PLEASE SUBMIT THIS COMPELTED FORM DIRECTLY TO:

TRY-AGAIN HOMES, INCORPORATED

103 EUCLID DRIVE

PARKERSBURG, WV 26102