Dental Visit Documentation

Resident Name: _____ D.O.B. _____

Physician Name: _____ Visit Date: _____

Reason for visit: _____

_____

Consumer's current medication: _____

_____

_____

Pertinent Medical History: _____

_____

_____

Current Treatment: _____

_____

_____

Recommendations/Follow Up: _____

_____

_____

Resident Accompanied by: _____