Dental Visit Documentation

Consumer Name: _____ D.O.B. _____

Physician Name: _____ Visit Date: _____

Reason for visit: _____

_____

Consumer's current medication: _____

_____

_____

Pertinent Medical History: _____

_____

_____

TO BE COMPLETED BY PHYSICIAN'S OFFICE

Dentist's Recommendations: _____

_____

_____

Current Treatment: _____

_____

_____

Progress Notes/Follow-up Plan: _____

_____

_____

Exam_____ X-Ray_____Prophy_____Extractions_____Restorations_____