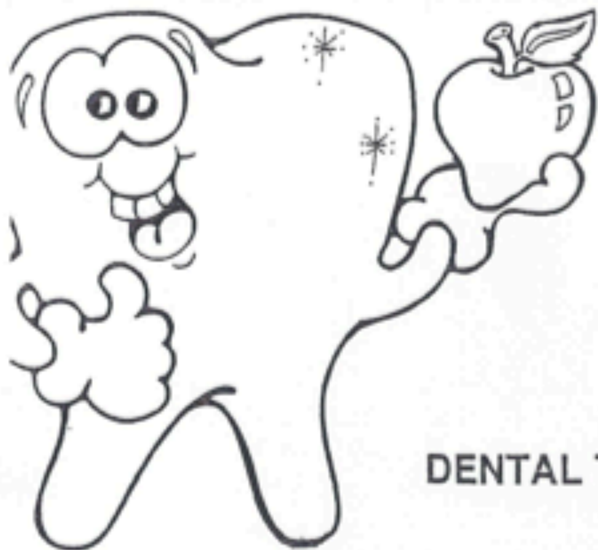

DENTAL TREATMENT VERIFICATION

Patient name:____

Date of birth:____

Date of last exam:____________________________________

Date of last cleaning:_________________________________

Date of last fluoride:_________________________________

Date of last X-rays:__________________________________

Recommended treatment:______________________________

____

Dentist name and address:____________________________

____

Dentist signature or official stamp:________________________