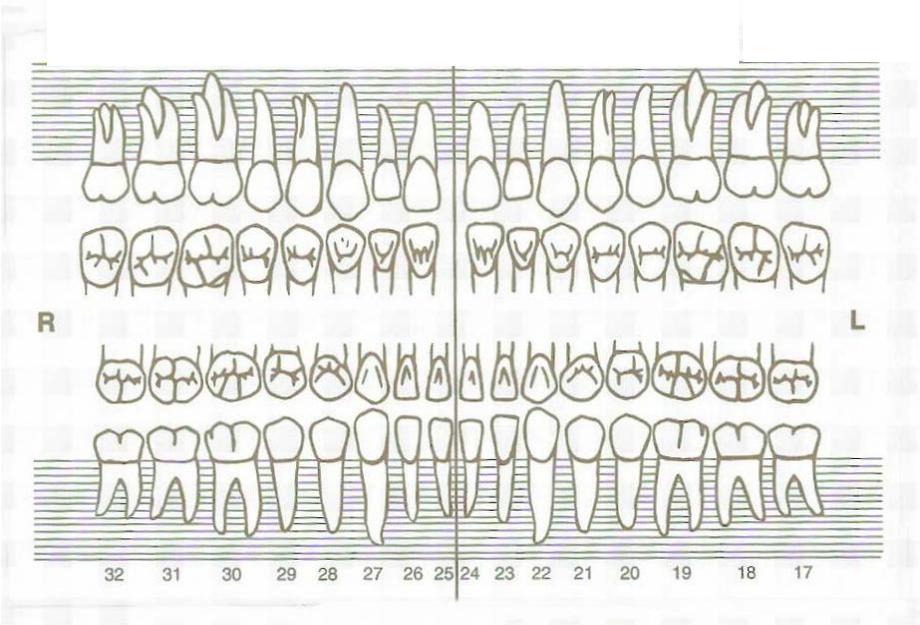
Record of Dental Examination

Name: _____ Date of Exam: _____

DOB :_____ Dentist: _____

DOP :_____ Program: _____



Remarks

Xrays taken
Yes ___ No___

Estimate of work to be completed:

Agency Approval: Yes ___ No___ Approved By: _____ Date: _____

Follow up dates:

_____ _____

_____ _____

_____ _____

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