77 Shoe House Road
York, Pennsylvania 17406
717-755-1033

# Record of Dental Exam

Client Name: _____ Date of Exam_____

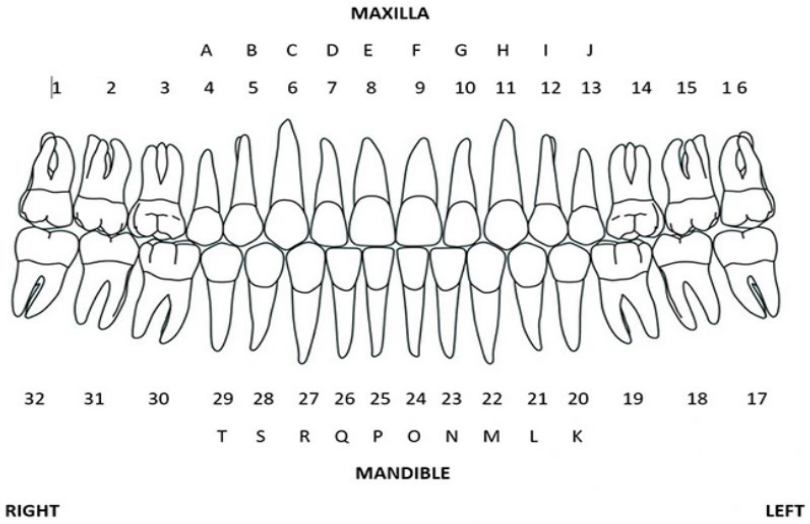
DOB:_____

DOP: _____

Dentist Office Name: _____

Adress of Dental Office: _____

Remarks:




X-rays taken: ____Yes ____ No

Estimate of work to be completed:

Dates of follow up:

_____
Dentist Name Printed

_____ _____
Dentist Signature Date