

Date of Exam _____

The following services have been performed:

_____ radiographs

_____ oral prophylaxis

_____ fluoride treatment

_____ restorations

The following statements are applicable: (please check)

_____ all necessary services have been performed.

_____ further treatment is indicated.

_____ no restorative services are required at this time.

_____ future appointments have been arranged.

Comments:

Signature of Dentist _____