

Date of Exam: \_\_\_\_\_

Student Name: \_\_\_\_\_

The following services have been performed:

\_\_\_\_\_ radiographs                      \_\_\_\_\_ oral prophylaxis

\_\_\_\_\_ fluoride treatment                      \_\_\_\_\_ restorations

The following statements are applicable:

\_\_\_\_\_ All necessary services have been performed.

\_\_\_\_\_ No restorative services are required at this time.

\_\_\_\_\_ Further treatment is indicated.

\_\_\_\_\_ Future appointments have been arranged.

Comments:

Signature of Dentist: \_\_\_\_\_