

House of New Hope

DENTAL EXAMINATION

FAX TO: (740) 745-3429

EMAIL TO: criticalincident@houseofnewhope.org

Routine Dental Exam is required every 6 months

Client Name: _____ DOB: _____

Date of Exam: _____

Abnormal Findings from Dental Examination:

Dentist's Recommendations:

Follow-up Visit Date/Time: _____

PRINT or STAMP

Dentist Name (printed): _____

Address: _____

City/State/Zip: _____

Telephone: _____

DENTIST'S SIGNATURE: _____ **DATE:** _____