FOSTER CHILD DENTAL EXAMINATION

______________________________ **(Name of Child)**

______________________________ **(Date of Service)**

The following services were performed: (Please check services performed)

Examination Visual ____________________

X-Ray ____________________

Cleaning ____________________

Fillings ____________________

Extractions ____________________

Other (Specify) ____________________

Next appointment if additional work is needed ______________________________
Date Time

Type of treatment needed:

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______________________________ Name and Address of Doctor

__(____)______________ Phone Number