Verification of Dental Treatment

This is to certify that ____________________________________is one of my regular Patients and was last seen in my office on _____________________.

The following applies to this patient:

_____ Needs no treatment at this time

_____ Needs a routine examination in the month of __________

_____ Needs the following services _________________________________

____

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_____ Appointment Scheduled for____________________

Comments:____

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Signature of Dentist___________________

Date____________________

As parent or Legal Guardian of ____________________________, I hereby give my Permission for the above information to be released to the Head Start Program.

Signature of Parent/Guardian__________________

Date___________________