On ___________________, ____________________________________ had dental services provided
(Date) (Name of Patient)

by:____

(Printed Name of Dental Provider/Public Health Dental Hygienist and Title)

Signature of Provider and Date_____________________________________ _____/____/________

A copy of this report was provided to: ____

SCREENING RESULTS

___ No obvious decay was noted; x-rays were not taken.
___ Areas of possible decay exist. You should be seen by a dentist in the near future.
___ Large areas of possible decay exist. You should be seen by a dentist as soon as possible.
___ Other dental problems may exist. You should be seen by a dentist as soon as possible.
___ There is an **immediate need for dental treatment** due to pain and/or infection.

Notes:____
____
____

ORAL HYGIENE RESULTS

___ Clean teeth and healthy gums were found.
___ Food/Plaque was found on teeth.

Oral Hygiene Instruction: ____
____
____

DENTAL SERVICES PROVIDED

Procedure Performed	ADA Code	Amount Billed
____________________	___________	$ __________
____________________	___________	$ __________
____________________	___________	$ __________
____________________	___________	$ __________
____________________	___________	$ __________
____________________	___________	$ __________

Notes:____
____
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If follow-up dental treatment is needed, a letter will be sent to the dentist of record, if one was listed on your medical history/consent form. If you have any questions concerning the dental services provided today or need assistance in locating a dentist, please contact ___________________________________ at XXX-XXX-XXXX or email at _______________________________________.