GENERAL DENTIST FORM

This form is to be completed by the applicant's general dentist

OR

[ ] If you do not have a general dentist please check this box and leave form blank

Date: _____

Applicant's Name: _____

Applicant's Date of Birth: _____

General Dentist: _____

Office Phone: _____

Date of last dental cleaning & exam: _____

Please list any restorative work that needs to be completed:

_____

_____

_____

_____

Please Check One:

_____ Patient has received a cleaning and is cavity free.

_____ Patient has received all restorative treatment including a cleaning with exam & no additional treatments are necessary.

_____ Patient has received cleaning with exam & restorative treatment has been scheduled.

Scheduled dates the restorative treatment is to be completed:

_____

_____

_____

Signature of Dentist