



STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES

DIVISION OF DEVELOPMENTAL DISABILITIES

Community Services Offices, Southern Region:

120 S. Stockton Street, 3rd Floor, Trenton, NJ 08611 (mail: P.O. Box 706, Trenton, NJ 08625-0706):

TELEPHONE: 609-292-1922/FAX: 609-292-2629

Juniper Plaza, 3499 Route 9 North, Suite 1-J, Freehold, NJ 07728: TELEPHONE: 732-863-4500/FAX: 732-863-4406

5218 Atlantic Avenue, Suite 205, Mays Landing, NJ 08330 – TELEPHONE: 609-476-5200/FAX: 609-909-0656

221 Laurel Road, Suite 210, Voorhees, NJ 08043 – TELEPHONE: 856-770-5900/FAX: 856-770-5935

TDD Users Can Call Through N.J. Relay 1-800-973-7899

DENTAL VISIT FORM

Patient's Name: _____ Date of Visit: _____ (Check ONE): ANNUAL OR FOLLOW-UP

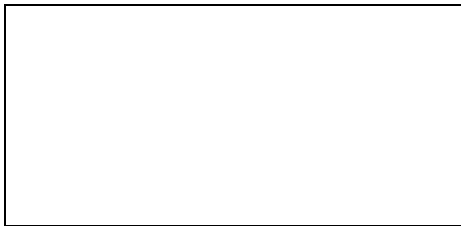
THE FOLLOWING CHECKED PROCEDURES WERE COMPLETED.

- 1. _____ CLEANING
- 2. _____ FILLING
- 3. _____ NOVACANE
- 4. _____ X-RAYS
- 5. _____ ROOT CANAL
- 6. _____ CROWN/CAP
- 7. _____ GUM SURGERY
- 8. _____ IMPRESSION
- 9. _____ SEDATION
- 10. _____ TOOTH EXTRACTION
- 11. _____ FLUORIDE TREATMENT
- 12. _____ OTHER

FOLLOW UP RECOMMENDED: YES _____ NO _____

If yes, please explain: _____

Date of next appointment: _____



DENTIST'S Stamp

DENTIST'S NAME: _____

(Print Name)

DENTIST'S Signature: _____

ADDRESS: _____

PHONE #: _____

DATE: _____

ALL INFORMATION WILL BE KEPT CONFIDENTIAL