Child Care Resources

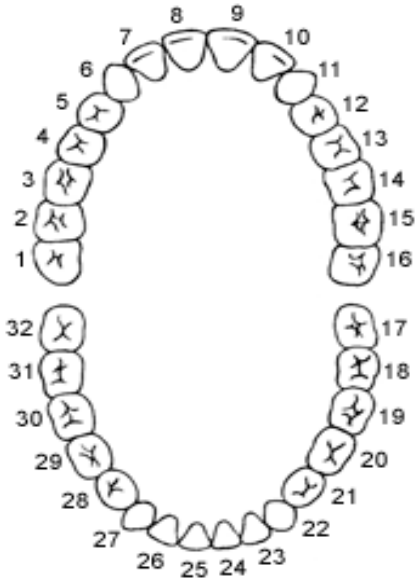
1580 Adams Lane, Zanesville, OH 43701
Phone (740)454-6251 Fax (740) 454-7369

Name_____ Date of Birth_____

Dentist Name_____ Address_____ Phone # _____

Examination and Treatment Record:

(Please note all treatment including cleanings and fluoride treatments)



Date	Tooth	Description of work	Treatment received
	All	☐ Exam,X-rays,Prophy & Varnish Complete	

Results of this exam indicates this patient needs:

_____ Routine visit, no treatment needed

_____ Treatment is needed (restoration, pulp therapy, extraction, etc.)

Approximate number of visits to complete work_____ Date scheduled_____

_____ All treatment was completed this visit,

_____ Other _____

I certify that I have completed the services listed in the exam section above.

Signature_____ Date_____
(Dentist's Signature)