8940290260

DENTAL PATIENT NOTIFICATION FORM

INFORMATION ONLY

Candidate #	Unit #

White Copy (CITA)
Yellow Copy (Candidate)
Pink Copy (Patient)

AMALGAM	COMPOSITE	PERIO
○ Prep	○ Prep	○
○ Finish	○ Finish	

Tooth # (if applicable): [ ][ ]

PATIENT INFORMATION

First Name

MI

Last Name

Mailing Address

City

State or Province

Zip Code -

Daytime Phone Number ( ) -

Evening Phone Number ( ) -

FOLLOW-UP CARE PROVIDER

First Name

Last Name

Physical Address

City

State or Province

Zip Code -

Daytime Phone Number ( ) -

Instructions to Follow-Up Care Provider:

1.) I understand that I will require an additional treatment for the reason(s) outlined above.

Patient's Signature ____________________ Date ____________

2.) I will make arrangements for the patient to have dental care provided as stipulated above.

Candidate's Signature ____________________ Date ____________

3.) The patient has been informed that follow-up care is necessary and that arrangements will need to to be made for patient treatment.

Chief Examiner/Designee Signature ____________________ Date ____________