3464220292

DENTAL COMPOSITE RADIOGRAPH VERIFICATION FORM

Candidate First Name

Candidate Last Name

I, _____, attest that these radiographs are a true and accurate representaton of the
(Candidate #)
clinical condition of _____ whom is being presented for
(Patient's Name)
treatment and that the radiographs have not been altered in anyway.

DATED THIS _____DAY OF _____, 20 ____.

FOLLOW-UP CARE PROVIDER INFORMATION

Patient First Name

Patient Last Name

Physical Address

City

State or Province

Zip Code

-

Daytime Phone Number

( ) -

In the event my patient will need follow-up care proceeding the examination, the following practitioner or facility will be providing such care:

First Name

Last Name

Facility Name

Physical Address

City

State or Province

Zip Code

-

Daytime Phone Number

( ) -

This form is to be completed and turned in at Candidate Registration!