8940290260

DENTAL PATIENT NOTIFICATION FORM

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

Tooth # (if applicable): ☐☐

Candidate # ☐☐☐ Unit # ☐☐☐

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

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 (☐☐☐) ☐☐☐ - ☐☐☐☐

Information Only

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 _____