

<b>DENTAL VISIT INFORMATION</b>
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**SECTION A - TO BE FILLED OUT BY FACILITY REPRESENTATIVE PRIOR TO VISIT**

CLIENT NAME:	UCI#:	DOB:
PHYSICIAN NAME:		
REASON FOR VISIT:	VISIT DATE	
<b>CLIENT MEDICATIONS:</b> Medication: Dosage: Frequency: _____ _____ _____ _____ <b>PERTINENT MEDICAL HISTORY:</b> _____ _____		

**SECTION B - TO BE FILLED OUT BY DENTIST'S OFFICE AT TIME OF VISIT**

<b>Dentist's Recommendations:</b> _____ _____
<b>Current Treatment:</b> _____ _____ _____
<b>Progress Note/Follow-up Plan:</b> _____ _____ _____
EXAM _____ X-RAY _____ PROPHY _____ EXTRACTIONS _____ RESTORATIONS _____

\_\_\_\_\_  
DENTIST'S SIGNATURE\_\_\_\_\_  
DATE\_\_\_\_\_  
FACILITY REPRESENTATIVE\_\_\_\_\_  
DATE