

Spectrum Community Services

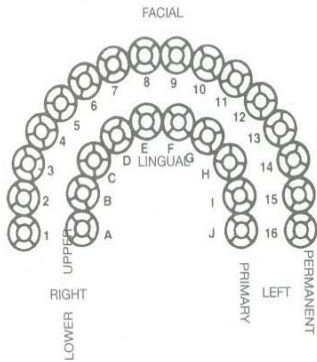
Consumer Dental Form

Consumer Name: _____

Dentist / Dental Professional Name: _____

Appointment Date: _____

Annual Cleaning / Exam _____ Reason for Appointment _____ Emergency _____



Please indicate any missing teeth, areas of heavy plaque, bleeding or any areas of concern

- Does follow up work / exam need to be completed? _____
- IF YES, Have X-rays been sent to Dentist? _____
- Is consumer hygiene being completed to a satisfactory degree? _____

Comments:

Dentist / Dental Professional

Date