



Wild Plum Center

DENTAL EXAM FORM

Date of exam _____

*This form needs to be completed by the dentist!
El Dentista del niño(a) necesita completar esta forma!*

Child's Name _____ DOB _____

<u>Preventative services received</u>	<u>Dental treatment received</u>
<ul style="list-style-type: none"> Bitewing films Cleaning Fluoride varnish Oral hygiene instruction Other 	<ul style="list-style-type: none"> Extraction Pulp therapy Restoration Other

Tooth Number or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed			A.D.A. Procedure Number	Actual Charges (Fees)
				MO	DAY	YR		

APPROXIMATE NUMBER OF VISITS TO COMPLETE WORK	
Date of next appointment	

SUMMARY	
All planned Treatment (_____ is _____ is not) COMPLETE	
Schedule for completion:	

Name of Dental Practice			
Address		Phone	
Signature of Dentist			

Submit form by email to enrollment@wildplumcenter.org or by postal mail to:
Wild Plum Center, Attn. Enrollment, 82 21st Avenue, Suite B, Longmont, CO 80501