



Dental Examination Verification

I hereby confirm that _____, presented at

(Patient Name) Please Print

my office on _____, 20____ and was provided with a preventative

(Month) (Day)

dental examination. Date of second preventative dental examination was

performed on _____, 20 ____.

(Month) (Day)

Signature: _____

Signature of Dentist or Dental Hygienist

Printed Name: _____

Date Signed: _____

Provider Address: _____

Phone: _____

Signature: _____

Signature of Employee or Spouse

Participant Email: _____

School: _____