DENTIST TREATMENT PLAN COMPLETION FORM

FOR DENTIST'S OFFICE USE ONLY

PLEASE PRINT

First Name		**Middle Initial**	
Last Name			
Address			
City		**State**	**Zip Code**
Smile for Life Category	❑ Child under the age of 5		
Visit Type	❑ Initial ❑ Regular 6 month check-up ❑ Phase 1 Dental Treatment Plan Completed ❑ Dental Treatment Plan Completed		
Early Childhood Measures Completed	❑ Completed a dental exam by age 12 months ❑ Completed a Phase 1 Dental Treatment Plan within 12 months of the initial exam between ages 12 to 60 months ❑ Received oral health education by the age of 48 months ❑ Received at least one fluoride varnish application between the ages of 12 to 60 months ❑ Received a fluoride assessment document		
Name of Referring Physician			
Dentist's Name and Contact Information			
Dentist's Signature		**Date**	/ /

For more information call
(724) 852-1001

Cornerstone Care
Foundation for a Healthy Future

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