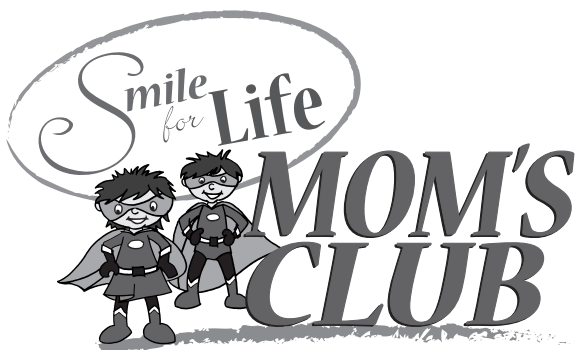




DENTIST TREATMENT PLAN COMPLETION FORM

FOR DENTIST'S OFFICE USE ONLY

PLEASE PRINT

First Name

Middle Initial

Last Name

Address

City

State

Zip Code

Smile for Life Category

☐ Pregnant Woman

☐ Child under 1 year of age

Visit Type

☐ Initial

☐ Regular 6 month check-up

☐ Phase 1 Dental Treatment Plan Completed

☐ Dental Treatment Plan Completed

Perinatal Measures
Completed

☐ Completed a comprehensive dental exam while pregnant

☐ Completed a Phase 1 Dental Treatment Plan within 6 months of the initial exam

☐ Developed self management goal

☐ Referred by medical staff

☐ Received patient education for oral health while in a medical setting

☐ Completed recommended periodontal treatment while pregnant

Name of Referring Physician

Dentist's Name and
Contact Information

Dentist's Signature

Date

/

/

For more information call
(724) 852-1001



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