Smile for Life MOM'S CLUB

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

Cornerstone Care
Foundation for a Healthy Future

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