Dental Visit Record

Provider Information

**Required fields are denoted with a '*'.*

TIN #*: _____

NPI ID*: _____**or Medicaid ID*:** _____

Name: _____

Phone: _____

Fax: _____

Service Date*: _____

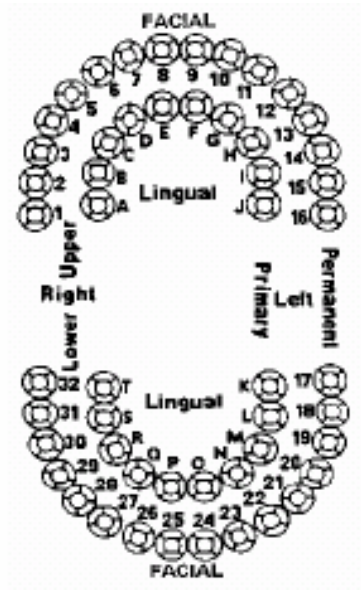
Member Information

First Name*: _____

Last Name*: _____

DFPS ID*: _____**or Medicaid ID*:** _____

DOB*: _____



Examination and Treatment Plan – List in order from Tooth #1 through Tooth #32				
Date Service Performed	Tooth # or Letter	Tooth Surface	ADA Procedure Number	Description of Services

Referrals

Referred By:	Referred To:	Reason	Date

Comments

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