Annual Dental Cleaning Examination Verification

I hereby confirm that____, presented at

(Patient Name) Please Print

my office on ______________________, 20_____, and was provided with an annual dental cleaning and examination. (Month) (Day)

Signature:____

Signature of dentist or dental hygenist

Printed Name:____

Date Signed:______________________________________

Provider Address:

____

____

Phone:____

Patient Signature:____

School District or College:____

Date of Birth:______________________________

Home Zip code:_________________________

Return to Carmen Terry, Health and Wellness Coordinator at cterry@iu17.org, Confidential Fax to 570-320-1348 or Mail to PO Box 3609, Williamsport, PA 17701