Northern Virginia
Family Service

REPORT OF DENTAL VISIT

Name of Child_____

Date of Birth: _____ **Date of Dental Visit**: _____

Dentist Name:_____ **Phone**: _____

Address: _____

Reason for Visit/ Dental Work Performed:

Recommendations include:

Medications prescribed? _____ Yes _____ No

If yes, name of medication prescribed.

_____

Follow-up visit needed? _____ Yes _____ No If yes, Date:_____

_____ _____

Signature of Dentist or Dentist Designee **Date**