



## DENTAL SERVICES

<b>NAME OF PATIENT</b>	
<b>DATE OF BIRTH</b>	
<b>ADDRESS</b>	
<b>CONTACT NUMBER</b>	

Please be hereby informed that the following dental services were rendered to above patient.

Teeth extracted: \_\_\_\_\_

Fillings done : \_\_\_\_\_

Other services (please specify): \_\_\_\_\_

Follow-up services needed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Thank you for your co-operation.

\_\_\_\_\_  
Dentist

\_\_\_\_\_  
Date