THE SALVATION ARMY
SOUTHERN AFRICA TERRITORY
HESKETH KING TREATMENT CENTRE

DENTAL SERVICES

NAME OF PATIENT:
DATE OF BIRTH:
ADRESS
CONTACT NUMBER:

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 :
____
____
____

Dentist Name and Surname: ______________________________

Dental Clinic: ______________________________

Date: ______________________________

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