

DELAWARE HEALTH AND SOCIAL SERVICES DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES COMMUNITY SERVICES

Dental Appointment Information Record (DAIR)

Name:		MCI:		Date of Visit:
Hygiene:	Good \square	Fair		Poor
Comments:				
Cancer Check:	Normal \Box	Abno	rmal	
Comments:				
SBE Prophylaxis: (Antibiotic prior to		Yes		No \square
Comments:				
Recommended Fre	quency of Dental	l Visits:	3 moi	nths □ 6 months □ Yearly □
Other:				
Dental Work Comp				
•				
Home Care Instru	ctions:			
Prescriptions/Trea				
- 1 - 0 - 0 - 1 - 1 - 0 - 0 - 1 - 1 - 0 - 0				
Needed Follow-Up	<u> </u>			
Next Appointment	Date:			
Comments:				
Signa				Date
	ider:			
Practice:				
Address:				
Phone:				

Revised: 6/2023