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

DENTAL SERVICE

NAME:_____ DATE:_____ MCI NUMBER:_____

HYGIENE: - GOOD ☐ FAIR ☐ POOR ☐

Comments:_____

CANCER CHECK: NORMAL ☐ ABNORMAL ☐

Comments:_____

SBE Prophylaxis: YES ☐ NO ☐

Comments:_____

Recommended Frequency of Dental Exams: 3 mo ☐ 6 mo ☐ Yearly ☐

Other:_____

Dental Work Completed Today: _____

_____

_____

Prescriptions / Treatments: _____

_____

_____

Home Care Instructions: _____

_____

_____

Needed Follow-Up: _____

Next Appointment Date: _____

Comments: _____

_____

_____ _____

Name Signature

PRACTICE: _____

ADDRESS: _____

_____

PHONE: _____