Form 3

CERTIFICATE OF ORAL HEALTH

Patient's Name:______________________________ Age:__________

Address:______________________________ Phone:__________

______________________________ Date:__________

TO BE COMPLETED BY DENTIST OR PHYSICIAN (Practitioner):____________________

RADIOGRAPHIC EXAM: (Patient's Option) - Accepted - Declined

ORAL EXAM: State Visible Abnormalities

Soft Tissue:

Hard Tissue:

RECOMMENDATIONS:

PRACTITIONER:____________________ (Signature)

PRINT:____________________ M.D./D.D.S.

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DENTURIST:____________________ PATIENT:____________________
(Signature) (Signature)

DATE:____________________

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Denturist Copy
Practitioner Copy

NOTE: Original to be given to Denturist, a copy to be retained by practitioner.