OVERBROOK SCHOOL FOR THE BLIND
DENTAL VISIT RECORD

Please complete the lower part of this form and return it for record purposes.
Thank you.

Child's Name: ______________________________ **Date of Birth:** ________________

Date of Visit: ______________________________

Name of Dentist (please print): ______________________________

Clinic/Hospital: ______________________________

Phone Number: ______________________________

Purpose of Visit: ______________________________

Pertinent Findings/Treatment: ______________________________

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Medication-including dose and times to be given: ______________________________

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Recommendations and Instructions: ______________________________

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Return Visit Date: ______________________________

______________________________ ______________________________

Signature of Dentist **Date**