Children's Services of Virginia, Inc.
P. O. Box 1069, Harrisonburg, VA 22803
(540) 801-0900 Fax: (540) 801-0886

DENTAL EXAMINATION VERIFICATION

Child's Name: _____

Dentist: _____ Date of examination:_____

Dental health status: **(Circle One)** Good Fair Poor

Treatment provided on this date: _____

_____

_____

Recommendations: _____

_____

_____

Next appointment: _____

_____
Dentist Signature **Date**

_____
Address

_____
Phone Number **Fax Number**