STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES
Community Services Offices, Southern Region:
120 S. Stockton Street, 3rd Floor, Trenton, NJ 08611 (mail: P.O. Box 706, Trenton, NJ 08625-0706):
TELEPHONE: 609-292-1922/FAX: 609-292-2629
Juniper Plaza, 3499 Route 9 North, Suite 1-J, Freehold, NJ 07728: TELEPHONE: 732-863-4500/FAX: 732-863-4406
5218 Atlantic Avenue, Suite 205, Mays Landing, NJ 08330 – TELEPHONE: 609-476-5200/FAX: 609-909-0656
221 Laurel Road, Suite 210, Voorhees, NJ 08043 – TELEPHONE: 856-770-5900/FAX: 856-770-5935
TDD Users Can Call Through N.J. Relay 1-800-973-7899

DENTAL VISIT FORM

Patient's Name:____________________Date of Visit: ___________(Check ONE): ANNUAL ☐ OR FOLLOW-UP ☐

THE FOLLOWING CHECKED PROCEDURES WERE COMPLETED.

1. _____ CLEANING	7. ______ GUM SURGERY
2. _____ FILLING	8. ______ IMPRESSION
3. _____ NOVACANE	9. ______ SEDATION
4. _____ X-RAYS	10. ______ TOOTH EXTRACTION
5. _____ ROOT CANAL	11. ______ FLUORIDE TREATMENT
6. _____ CROWN/CAP	12. _______ OTHER

FOLLOW UP RECOMMENDED: YES _____ NO______

If yes, please explain: ____

____

____

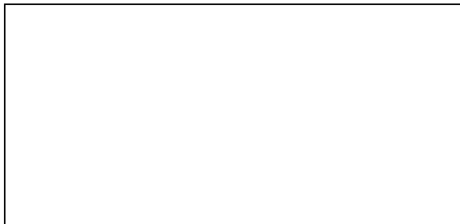
Date of next appointment: _________

DENTIST'S NAME:____
(Print Name)

DENTIST'S Signature: ____

ADDRESS: ____

PHONE #:____



DENTIST'S Stamp

DATE: ____

ALL INFORMATION WILL BE KEPT CONFIDENTIAL