Proof of Dental Examination Form

Patient Information

Name: _____

Date of Birth: _____

Gender: [ ] Male [ ] Female

Contact Number: _____

Address: _____

Examination Details

Date of Examination: _____

Examining Dentist: _____

Clinic Name: _____

Findings Summary

[ ] Teeth in Healthy Condition

[ ] Dental Issues Identified (explain): _____

Procedures Performed

[ ] Cleaning

[ ] X-Ray

[ ] Filling

[ ] Other (specify): _____

Recommendations

[ ] Routine Check-Up in 6 Months

[ ] Follow-Up Treatment Required

Certification by Dentist

I, _____, certify that the above patient has undergone a complete dental examination on _____.

Signature: _____ Date: _____

License Number: _____