



## GENERAL DENTIST FORM

This form is to be completed by the applicant's general dentist and/or hygienist

OR

[ ] If you do not have a general dentist please check this box and leave form blank

Date: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_

Applicant's Date of Birth: \_\_\_\_\_

General Dentist: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Date of last dental cleaning & exam: \_\_\_\_\_

Please list any restorative work that needs to be completed:

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Please Check One:

\_\_\_\_\_ Patient has received a cleaning and is cavity free.

\_\_\_\_\_ Patient has received all restorative treatment including a cleaning with exam & no additional treatments are necessary.

\_\_\_\_\_ Patient has received cleaning with exam & restorative treatment has been scheduled.

Scheduled dates the restorative treatment is to be completed:

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\_\_\_\_\_  
Signature of Dentist/Hygienist

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Cambridge, ON N1R 6J1

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Waterloo, ON N2J 2J9

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