Authorization for Treatment

Dear Doctor ___________________:

I'm currently a student at the University of Oregon, and am requesting interim _____________________ (specify) services at the University Health Center Dental Clinic.

To authorize my treatment and maintain continuity of my dental care please complete this pre-treatment form.

Date of most recent exam: _________________ ***(Must be less than one year since last exam for UO dental eligibility.)***

Next exam in your office due: ______________ *(mo/yr)*

Areas of concern: ___________________________________

Specify radiographs that you would like exposed and forwarded to your office :
____*BW's;* ____*PA's;* _____ *Specific to site of discomfort, pain. or change.*

*********PLEASE ENCLOSE ANY CURRENT FILMS***********

Specify further radiographic instructions:

____

____

Last scale/root plane date: ___________ *w/recall recommended every* ____ *months.*
*Perio Case Type:*________*(I;II:III, etc)* *Specify any areas of periodontal concern:*

____

____

Would you like a copy of the data collected at this appointment (circle): *yes / no*

*If yes, mailing address:*____

***Dentist Signature*: ____**

Please return this completed form to me at my address below, Thank You!
*
*
*
Name & mailing address, please print
*
*
Student ID number & telephone number:____

Dental Health Clinic (541)346-2791/ Appts are scheduled for Tues and Thurs / one hour in length.