Dental Visit Sign-In Sheet

Dental Consultant Name: _____

Time Exams Began: _____ Time Exams Ended: _____

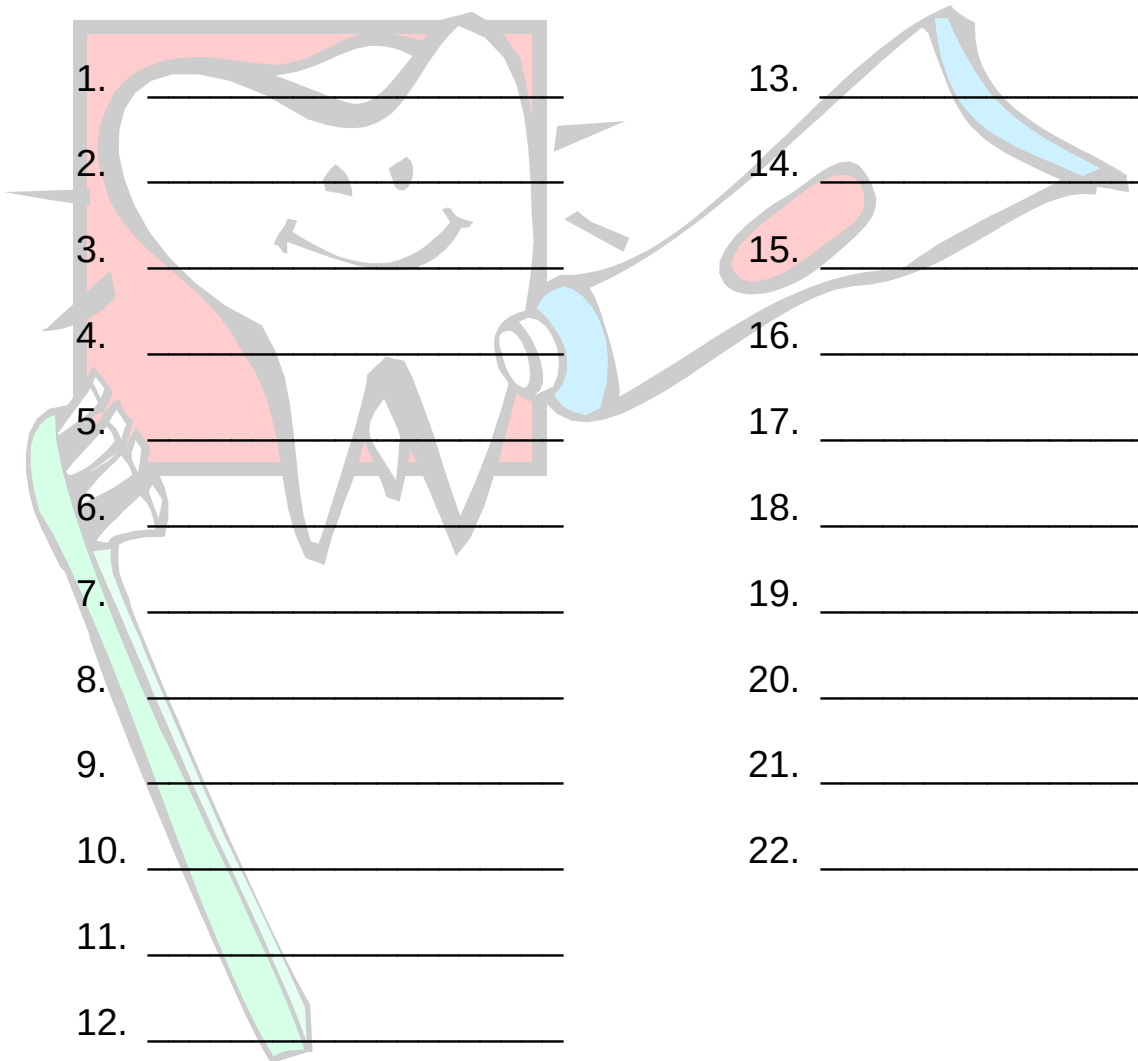
Accompanying H/N Specialist: _____

Center Name: _____ LOC ID: _____

FSW Name: _____

Date of Examination: _____

Children that received the examination *(ONLY WRITE IN THE CHILDREN WHO ARE PRESENT FOR THE EXAM AND WERE SEEN BY THE DENTIST):*



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***Please submit a copy of this completed form along with the pink exam copies to SOP Health Services.**

Revised 8/15