THRIVE
DENTAL & ORTHODONTICS

COMPLETED TREATMENT FORM

Patient Name: _____ DOB: _____

Treating Office: _____ Treating Doctor Name: _____

Date Completed: _____ Tooth Number(s) and Treatment Completed: _____

_____

_____

____ Pt will return to YOU office; all referred treatment completed

____ Pt will return to OUR office for the following treatment: _____

Date of Next Visit: _____

Estimated Insurance Benefits Used: _____

Patient Deductive Met (circle one): Yes No

Additional Notes: _____

_____

_____

Employee Name: _____ Date: _____