TEXAS WORKFORCE SOLUTIONS

Texas Workforce Commission
Vocational Rehabilitation Services

Dental Report

The information requested is necessary to help counselors determine treatment needs for the person named.

Return Information

Return Report to (Name):			Telephone Number:
Address:	City:	State:	ZIP Code:

Patient Information

Name:	Date of Birth:	Social Security Number:	Telephone Number:

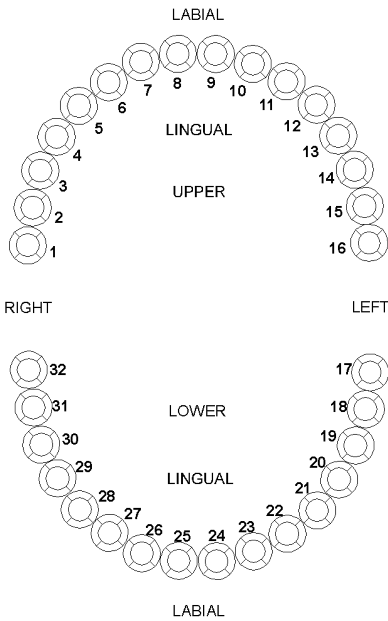
Reported Disability:

Reason for Referral:

Examination and Treatment Record

To the dentist. Examination authorization does not allow for proceeding with definitive dental care. Complete all applicable items and return for treatment authorization.

Use charting system shown. One tooth number, one procedure, and one estimated fee per line. For prosthesis (fixed or removable), indicate teeth to be replaced.



Mark "X on the chart above to indicate missing teeth.

Tooth Number	ADA Code Number	Description of Services (Including X-rays, prophylaxis materials used, etc.)	Estimated Fee	DRS Use Only

Treatment period - number of months:	Total Fee:
Is any of the treatment for orthodontic purposes? ☐ Yes ☐ No	Is the major dental condition: ☐ acute? ☐ slowly progressive? ☐ static?
If prosthesis, is this initial placement? ☐ Yes ☐ No	If no, reason for replacement:

Give summary statement of condition of mouth:

Remarks for unusual services:

All information is to be treated as confidential.
Examinee has the legal right to see this report when the examinee requests.

Type or Print Dentist's Name:	Telephone Number:

Dentist's Address:	City:	State:	ZIP Code:

Examining Dentist's Signature:	Date of Examination: