"Show Your Smile"
2020/21

PATIENT NAME: _____

SCHOOL/BUILDING: _____

NAME OF DENTAL PROVIDER: _____

DATE OF DENTAL VISIT: _____

INFORMATION RECEIVED:

Check those that apply

- ❒ ORAL EXAM
- ❒ DENTAL CLEANING
- ❒ COMPLETED "HEALTH *THROUGH* ORAL WELLNESS® PROGRAM" (HOW®) CLINICAL RISK ASSESSMENT
- ❒ OTHER DENTAL SERVICES: _____

DENTAL CARE PROVIDER SIGNATURE: _____

I agree that this patient has participated in a routine dental checkup.

PATIENT SIGNATURE: _____

PARTICIPANT INSTRUCTIONS

To earn 25 PATHpoints you must…

Return this form to _____ no later than June 1, 2021.

25 PATHpoints will be added to your PATH account on or before June 15, 2021.