



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 and current bitewings or FMX must be enclosed with the completed form.)

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, and the current bitewings or FMX, to me at my address below,
Thank You!

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*
*

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.