

## MEDICAL AND/OR DENTAL CARE RECORD

Consumer's Name: \_\_\_\_\_

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Date of Visit: \_\_\_\_\_ Name of Physician or Dentist: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

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Treatment and/or Medication Prescribed: \_\_\_\_\_

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Signature of person making entry: \_\_\_\_\_

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Date of Visit: \_\_\_\_\_ Name of Physician or Dentist: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

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Treatment and/or Medication Prescribed: \_\_\_\_\_

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Signature of person making entry: \_\_\_\_\_

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Date of Visit: \_\_\_\_\_ Name of Physician or Dentist: \_\_\_\_\_

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Date of Visit: \_\_\_\_\_ Name of Physician or Dentist: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

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Treatment and/or Medication Prescribed: \_\_\_\_\_

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Signature of person making entry: \_\_\_\_\_