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|  | | **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: | | | | Case ID 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 | | VR Use Only |
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| 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:  **X** | | | | | | | | Date of Examination: | | | | | | | |