

Ardmore Enterprises, Inc.

DENTAL APPOINTMENT

Name: _____ Date: _____

Address: _____ Age: _____ Sex: _____

Previous Extractions:

() Local Anesthesia () General Anesthesia

() Slight Bleeding () Bleeding Normal () Bleeding Heavy

Post-operative Healing: () Normal () Surgical Dressings

Osteitis: _____

ORAL EXAMINATION

Gingiva: Maxilla _____

Treatment performed at

Mandible _____

Growths: _____

Occlusion: _____

Ulcerations: _____

Other Conditions: _____

Missing teeth and existing restorations, indicate work

Dentures	Type	Satisfactory	Unsatisfactory
Maxilla			
Mandible			

Service Rendered: _____

Recommendations: _____

Dentist's Signature

Printed Name

Address

Phone

Ardmore Enterprises, Inc.

MEDICATION/TREATMENT ORDER FORM

Ardmore Enterprises, Inc
3010 Lottsford Vista Rd. Mitchellville MD 20721

NOTE: A non-medical program person may be administering medication/treatment. If possible, arrange a time for administration so that medication/treatment **will not** be given during work program hours (8:30 am – 3:30pm).

NAME: _____ ADDRESS: _____

TELEPHONE #: _____ COUNSELOR WITH PATIENT: _____

PLEASE LIST ALL MEDICATIONS/TREATMENT THAT HAVE BEEN ORDERED AND/OR CANCELLED

NAME OF MEDICATION/TREATMENT				
DOSAGE				
HOURS/TIMES TO BE GIVEN				
METHOD TO GIVE MEDICATION/TREATMENT				
PURPOSE OF MEDICATION/TREATMENT				
STOP DATE				
POSSIBLE COMMON SIDE EFFECT(S)				
CONDITIONS FOR WHICH HEALTH CARE PROFESSIONALS MUST BE CONTACTED				

HEALTH CARE PROFESSIONAL
SIGNATURE-PRINTED: _____ DATE: _____

SIGNATURE-SIGNED: _____ DATE: _____

THIS FORM MUST BE KEPT CURRENT