Dental Routine Preventive Care Form

Date: ______________________________

Name of Patient: ______________________________

Date of Cleaning: ______________________________

This is to certify that the above-named patient was seen in my office on the date above and had a routine preventative cleaning.

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Authorized Dental Office Signature *Date*

Name of Practice (or dentist office stamp):

This document is not a guarantee of coverage; for specific preventive guidelines, as well as confirmation of eligibility and limitations of coverage, please contact the carrier directly.