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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:      |