

Ariel Clinical Services

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PHONE 303-703-9351
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1520 N. Union Blvd., Suite 100
Colorado Springs, CO 80909
PHONE 719-260-6110
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DENTAL EVALUATION

Name of Child: _____ Date of Birth: _____

Name of Treating Dental Professional: _____

Address: _____ Phone: _____

I have read and understand the items marked above, authorization for the releases shall cease upon termination of present services.

Date	Procedure / Treatment
	<input type="checkbox"/> Cleaning/Exam <input type="checkbox"/> Filling <input type="checkbox"/> X Rays <input type="checkbox"/> Other _____

Results / Comments: _____

Next Scheduled Appointment: _____

Name of Doctor (*please print*): _____

Address: _____ Phone: _____

Doctor's Signature: _____ Date: _____

Foster Child's Signature: _____ Date: _____