DENTAL
McDONOUGH
Mobile Dental Services

REQUEST FOR SCREENING FORM

NAME OF PATIENT _____ DATE _____

FACILITY _____ ROOM # _____

INITIAL SCREENING ( ) EMERGENCY CARE ( )

NATURAL TEETH ( ) DENTURES ( ) BOTH ( )

ADDITIONAL INFO (Pain , swelling, dentures don't fit, can't eat properly, etc…)

_____

_____

_____

Please List name of financially responsible party

NAME: _____

ADDRESS _____

PHONE _____

EMAIL _____

I/we authorize McDonough Dental –Mobile Services to complete an initial screening for the resident listed above. I/we consent to the release of all necessary contact information to McDonough Dental –Mobile Services to facilitate direct and efficient communication in regards to dental treatment.

Signature _____

Print Name _____

Date _____

T: 905.330.8156
F: 905.383.6628
mcdonoughdentalmobileservices@gmail.com
575 Upper James Street, Hamilton, ON L9C 2Y7