Incomplete Dental Treatment

Patient Name ______________________________ Date: ____________

Dear ______________________________ : 

Just a friendly reminder: Your dental care has not been completed. Your last visit was on ____________. You still need the following treatment:

__________________________________________________________________________________________________________________________________________________

Purpose of Planned Care:

☐ Improve smile, appearance
☐ Help bleeding, mouth odor
☐ Treat gum or bone infection
☐ Preventive, examination
☐ Old work leaking, worn out
☐ Tooth broken, infected
☐ Cavity getting worse
☐ Tooth too weak
☐ Teeth shifting or loose
☐ Bite, Joint problem
☐ Root canal tooth may break, re-infect or decay beyond repair
☐ Temporary crowns can leak, break and allow gum disease or decay beyond repair.
☐ Condition will worsen, cost more or cause pain if delayed
☐ Additional dental care is also needed. __________________________________________
☐ Other __________________________________________________________

____________________________________________________________________________________________________________

We are concerned about you!

Please call us at ________________ as soon as possible!

Sincerely,

Your Dental Practice

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