

Charitable Dental Care Reporting Form



Date of Care / Zip Code of Tx	Number of Patients Seen	Amount of Care Provided	Was the care part of an event?	Did any group help arrange this care?																
Date of Care: _____	_____ Children	Total Hours: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes																
Zip Code of Treatment: _____	_____ Adults	<table border="0"> <tr> <td>TYPE of CARE</td> <td>\$ AMOUNT</td> </tr> <tr> <td><input type="checkbox"/> Preventive</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Restorative</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Emergency</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> <tr> <td colspan="2"><u>Other Description:</u> _____</td> </tr> <tr> <td colspan="2">_____</td> </tr> <tr> <td colspan="2">_____</td> </tr> </table>	TYPE of CARE	\$ AMOUNT	<input type="checkbox"/> Preventive	_____	<input type="checkbox"/> Restorative	_____	<input type="checkbox"/> Emergency	_____	<input type="checkbox"/> Other	_____	<u>Other Description:</u> _____		_____		_____		<input type="checkbox"/> No	<input type="checkbox"/> No
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<u>Other Description:</u> _____																				

			If yes, what event? _____ _____ _____ _____ _____	If yes, what group? _____ _____ _____ _____ _____																

You can help by recording the charitable dental care that you provide on this form and returning it to:

PO Box 3710
Wilsonville, OR
97070-3710

or

Fax to
503-218-2009

If you wish to record additional events, please make copies of this form.

Thank you for your help!

Comments: _____

I see Oregon Health Plan / OMAP patients.
 I see Oregon Health Plan / OMAP patients, but do not bill for those services.