

Treatment Redo Form

Request Date _____ Office Name _____

Patient Name _____

Original Treatment Provider _____ Treatment Date _____

Redo Treating Provider _____

Treatment to be redone - must include original treatment date, code, tooth #, and amount

_____	_____
—	_____
_____	_____
—	_____
_____	_____
—	_____
_____	_____
—	_____

_____ **FOR MANAGER USE ONLY** _____

Office Manager Signature

Date

Jay Rana Signature

Date