



“Show Your Smile” 2023/24



PATIENT NAME: _____

SCHOOL/BUILDING: _____

NAME OF DENTAL PROVIDER: _____

DATE OF DENTAL VISIT: _____

INFORMATION RECEIVED:

Check those that apply

- ORAL EXAM
- DENTAL CLEANING
- COMPLETED “HEALTH THROUGH ORAL WELLNESS® PROGRAM” (HOW®) CLINICAL RISK ASSESSMENT
- OTHER DENTAL SERVICES: _____

DENTAL CARE PROVIDER SIGNATURE: _____

I agree that this patient has participated in a routine dental checkup.

PATIENT SIGNATURE: _____

PARTICIPANT INSTRUCTIONS

To earn 25 PATHpoints you must...

Return this form to _____ **no later than June 1, 2024.**

25 PATHpoints will be added to your PATH account on or before June 15, 2024.

(only one Show Your Smile form per points year will be accepted)