"Show Your Smile"
2024/25

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, 2025.

25 PATHpoints will be added to your PATH account on or before June 15, 2025.

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