Dr. Allan Hynes Periodontist Inc.

Confidential Patient Treatment Record

Date_____

Surname_____
First Name Middle Initial

Date of Birth_____ Are you a Canadian Citizen? _____
month day year

Address: _____
postal code

Home Phone # _____ Bus. Phone #_____

E-mail Address: _____ Cell # _____

Occupation: _____ Place of employment: _____

Referred by:_____

Next of Kin_____ Phone #: _____

Address: _____

Do you need a Dental Insurance form? _____ MCP #_____

This is a scent free office (sign here) _____

Treatment Plan

Date Completed	Prob. #	Problem Description	Units of Time Needed	CDA Code