

Metro Denver Dental Foundation Domestic Violence Dental Care TREATMENT CONCLUSION Report

Please complete and return this form to us upon completion of treatment. All information recorded on this form is confidential. We record the value of services provided to certify that the full value of your contribution is tax deductible to the extent of the law and to determine the collective value of all patient treatment provided through the program.

Date: _____

Doctor Name: _____

Telephone Number: _____

E-mail: _____

Patient Name: _____

Date Treatment Concluded: _____

Treatment Length: _____

Services Provided (or attach tx est.):

Value of Service:

1. _____

\$ _____

2. _____

\$ _____

3. _____

\$ _____

4. _____

\$ _____

5. _____

\$ _____

6. _____

\$ _____

7. _____

\$ _____

Total Value of Services Provided

\$ _____

Remarks:

_____ Yes, I would be willing to evaluate a future patient through the MDDS/MDDF Domestic Violence Dental Care Program.

THANK YOU!! Please return...

By Mail:
Attn: CONFIDENTIAL/DVDCP
MDDS
3690 South Yosemite Street, #200
Denver, CO 80237

By Fax:
(303) 488-0177