TEETH HUB DENTAL CLINIC

DENTAL TREATMENT PLAN & SCHEDULE

Patient Name: **John mark santos**		**Date:** Aug. 19, 2026	
Patient No.:		**Dentist:**	

TREATMENT SCHEDULE

SCHEDULE / DATE	TREATMENT / PROCEDURE
aug 19, 2026	Oral Prophylaxis
	Resto 17-O, 16-O,L, 24-O,D, 25-M, 26-O,L, 27-O, 37-B, 36-B,O, 46-O, (B), 47-O
	exo-28, 18 -odontectomy

TREATMENT STATUS □ Completed □ Partially Completed □ Rescheduled □ Cancelled □ Pending Patient Decision

FUTURE TREATMENT PLAN / CHECK-UP SCHEDULE

DATE / TARGET DATE	FUTURE TREATMENT / CHECK-UP
	removable denture(flexite)
	Orthodontic treatment

RECALL / FOLLOW-UP Next Check-Up: _____ Recommended Recall: □ 3 months □ 6 months □ 12 months □ As needed

Additional Notes / Instructions:

_____

_____

Patient Signature: _____Date: _____	Dentist Signature: _____Date: _____