444 Western Boulevard
Jacksonville, North Carolina 28546-6816 Phone
(910) 455-1221

Coastal Carolina Community College

Dental Examination Form

Patients Name: _____
Last First M.I.

Address: _____
Street/P.O. Box

_____
City State Zip

Phone: _____ **Date of Birth:** _____/_____/_____

Statement of Dentist: This is to certify that on _____,

20____, the applicant,_____, came to see me for
(Applicant's Name)

an examination of their teeth and gums which I found to be in _____

condition.

I have since given treatment necessary:

_____

_____

_____

Signature: _____ **Date:** ____/_____/_____
M.D./ O.D.

An Equal Opportunity Employer

Revised: 6/4/2025