

THE SALVATION ARMY SOUTHERN AFRICA TERRITORY



HESKETH KING TREATMENT CENTRE

DENTAL SERVICES

NAME OF PATIENT		
DATE OF BIRTH		
ADDRESS		
CONTACT NUMBER		
•		
Please be hereby info patient.	ormed that the f	owing dental services were rendered to above
Teeth extracted: Fillings done:		
Other services (pleas	se specity):	
Follow-up services n	reeded:	
Thank you for your o	co-operation.	
Dentist		Date