DENTAL EXAMINATION

NAME: ____________________________________ **DATE**: __________________________

MEDICATIONS: ____
____

MEDICAL PROBLEMS: ____
____

EXAMINATION:

Oral Hygiene

[ ] *Good*
[ ] *Plaque, slight*
[ ] *Plaque, moderate*
[ ] *Plaque. Heavy*
[ ] *Calculus, slight*
[ ] *Calculus, moderate*
[ ] *Calculus, heavy*
[ ] *Periodontal Disease, localized*
[ ] *Periodontal Disease, generalized*
[ ] *Mobility*

Teeth

[ ] *No clinical problems noted*
[ ] *White spots*
[ ] *Cavities*
[ ] *Recurrent decay*
[ ] *Malocclusion / Ortho*
[ ] *TMJ Dysfunction*
[ ] *Abscess*
[ ] *Fractured tooth/teeth*
[ ] *Impacted tooth/teeth*

CLINICAL SUMMARY:

[ ] No dental problems at this time.
[ ] Has the following conditions that require **Urgent Treatment**:

____

[ ] Has the following conditions that may require Future Treatment:

____

[ ] Preventive Dentistry Only

NEXT APPOINTMENT: ____

Additional notes/comments: ____

DENTIST INFORMATION

____ ___________________________
Signature of Examiner Date

____ ___________________________
Print Name Phone

____
Address City State Zip Code

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