DENTAL EXAM

Participant Name: _____

Appointment Date: _____

Reason for Visit: ☐ CLEANING/EXAM ☐ DENTAL WORK OTHER _____

I have provided a current list of medications and allergies. YES NO

_____

Provider Name (Print) Provider Signature Date

TO BE COMPLETED BY DENTIST:

1. Are there signs of improper brushing? YES NO _____
2. Is there any decay? YES NO _____
3. Is there any gum deterioration? YES NO _____
4. Are there any signs of infection? YES NO _____
5. Are there any abnormalities? YES NO _____
6. Is further treatment required? YES NO _____
7. Is a consult needed? YES NO _____

Explain further dental work needed:

_____

_____

_____

Review and instructions from today's appointment:

_____

_____

_____

Next cleaning/exam is due: _____

I have reviewed the current list of medications and allergies. YES NO

Is it safe for the client to receive PRN over-the-counter medications? YES NO

Explain:_____

_____

_____

Physician Name (Print) Physician Signature Date

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