DENTAL EXAMINATION

PATIENT (LAST / FIRST / MIDDLE) _____ Chart # _____

Chief Complaint _____

Last Dental Visit ___/___/___ Last X-Ray ___/___/___ Available ___Y ___N

Doctor's Name _____

Patient's Home Phone _____

Patient's Work Phone _____

PATHOLOGY

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J
T S R Q P O N M L K

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

MISSING TEETH & EXISTING RESTORATION

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J
T S R Q P O N M L K

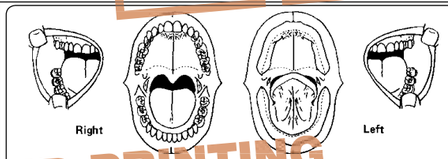
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

DIAGNOSIS

UCR	DATE:		OK	FEE
	X-Ray			
		Prophy FL (OHI)		
		Root Planing UR UL LR LL		
	1			
	2			
	3			
	4A			
	5B			
	6C			
	7D			
	8E			
	9F			
	10G			
	11H			
	12I			
	13J			
	14			
	15			
	16			
	17			
	18			
	19			
	20K			
	21L			
	22M			
	23N			
	24O			
	25P			
	26Q			
	27R			
	28S			
	29T			
	30			
	31			
	32			
	Total $			

ALTERNATE TREATMENT

DATE:		OK	FEE
X-Ray			
	Prophy FL (OHI)		
	Root Planing UR UL LR LL		
1			
2			
3			
4A			
5B			
6C			
7D			
8E			
9F			
10G			
11H			
12I			
13J			
14			
15			
16			
17			
18			
19			
20K			
21L			
22M			
23N			
24O			
25P			
26Q			
27R			
28S			
29T			
30			
31			
32			



SOFT TISSUE ORAL CANCER EXAM

WNL (Within Normal Limits)

- ❑ Head, neck, skin: _____
- ❑ Lips, labial, mucosa: _____
- ❑ Buccal mucosa: _____
- ❑ Hard, soft palate: _____
- ❑ Floor of mouth: _____
- ❑ Tongue: _____

Occlusion _____ TMJ _____

Blood Pressure _____ Pulse _____

PERIODONTAL INDEX

Sextant Score

Periotype: 0 | I | II | III | IV

1) Deepest pocket in sextant

2) Plaque (+,-) 2 | 3

3) Bleeding (+,-) 1

MEDIC ALERT

SEQUENCED TREATMENT

Phase I

Phase II

Phase III

Phase IV

	AGE	CONDITION
FUD		
FLD		
PUD		
PLD		
BB		

REFERRAL

- ❑ ORTHO
- ❑ PERIO _____
- ❑ ENDO _____
- ❑ ORAL SURGERY _____
- ❑ PEDO _____

Treatment Accepted by _____ **Patient's Signature** _____ **Date** ___/___/___

Patient's Name _____ Chart # _____ Dr.'s Name _____ Initials _____

Dr.'s Name _____ Initials _____

Hyg.'s Name _____ Initials _____

Asst.'s Name _____ Initials _____

DATE	TEETH	SERVICE RENDERED	INITIALS	CHARGE