

DENTAL EXAMINATION RECORD

PART III. ORAL DIAGNOSIS

Denture Possession: _____

A	B	C	D	E	F	G	H	I	J
<input type="checkbox"/>									

Upper _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
<input type="checkbox"/>															
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
<input type="checkbox"/>															
T	S	R	Q	P	O	N	M	L	K						
<input type="checkbox"/>															

Periodontal Diagnosis: _____

Date	Date	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Therapy or Evaluation Needed: _____

X-rays Reviewed: _____

Enamel Defects: _____

Soft Tissue/TMJ: _____

Orthodontics: _____

No. Need Tx. in Progress Completed

IV. PREVENTION ASSESSMENT

Status of:

Water Fluoride _____ ppm

Use of Fluoride Toothpaste _____

Other Fluoride Supplements _____

Oral Hygiene _____

Tobacco Use _____

Need for: _____

Topical Fluoride _____

Fluoride Tablets/Drops _____

Sealants _____

Hygiene Instruction _____

Other Education _____

Target Group: _____

VI. DEFERRED DENTAL NEEDS

Basic Care (level I - III Svcs) _____

Anterior/Bicuspid Endo _____

Molar Endodontics _____

Perio Pocket Therapy _____

Crowns/Complex Restor. _____

Removable Dentures _____

Fixed Bridge: Ant. _____ Post. _____

Surgery: 3rd Molars _____ Other _____

Ortho: Limited _____ Comp _____

PART V. TREATMENT PLAN

Referral / Followup: _____ Interval: _____

This treatment plan has been explained and I accept it.

Patient / Guardian _____ Date: _____

Dentist _____ Date: _____

PART I. DEMOGRAPHICS

HRN	SSN	
NAME		
B DATE	SEX	TRIBE
RESIDENCE		
FACILITY	DATE	

PART II. MEDICAL ALERT / UPDATE