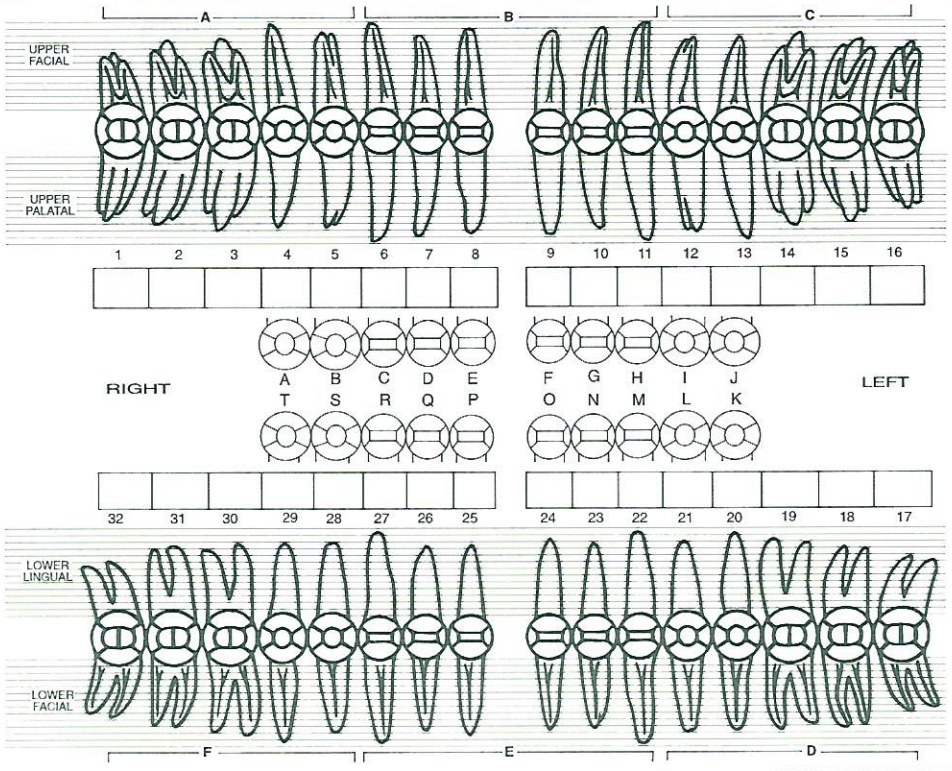
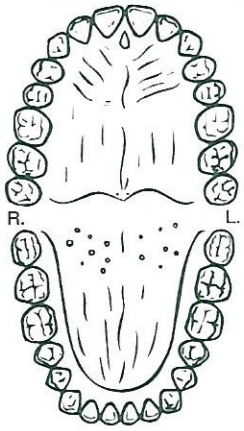
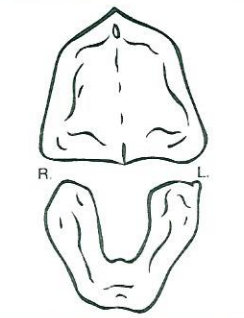
LAST NAME	FIRST NAME	HOME PHONE	HOME ADDRESS
SS #	EMPLOYER	BUSINESS PHONE	BUSINESS ADDRESS
RESPONSIBLE PARTY		NAME OF PHYSICIAN	PHONE
ADDRESS		ADDRESS	

DATE OF EXAM	MARITAL STATUS S M D W C	REFERRED BY	PATIENT #







DENTAL HISTORY	
LAST DENTAL VISIT?	WHAT SERVICES?
DID YOU HAVE X-RAYS?	REGULAR VISITS?
HAVE YOU LOST TEETH?	WHY?
COMPLICATIONS WITH THE EXTRACTIONS?	
MISSING TEETH REPLACED BY:	DENTURE?
FIXED BRIDGE?	REMOVABLE PARTIAL?
HAVE REPLACEMENTS BEEN DISCUSSED?	
HOW OFTEN DO YOU BRUSH YOUR TEETH?	
GUMS BLEED? YES/NO	WHEN?
FOOD COLLECTION BETWEEN YOUR TEETH?	
DO YOU EAT BETWEEN MEALS?	
ARE YOUR TEETH SENSITIVE? SWEETS? HOT? COLD?	
HOW DO YOU FEEL ABOUT YOUR TEETH IN GENERAL?	
ARE YOU PLEASED WITH THE APPEARANCE OF YOUR TEETH?	
HOW DO YOU FEEL ABOUT DENTURES?	

CLINICAL DATA			
GENERAL CONDITION OF TEETH			
ABRASIONS	PLAQUE	STAINS	
CONDITION OF PRESENT RESTORATIONS			
CONTACT POINTS	OVERHANGS		
INFLAMMATION OF GINGIVAL TISSUE			
SLIGHT	MODERATE	SEVERE	
COLOR	POCKETS	RECESSION	
CONDITION OF THE FLOOR OF THE MOUTH			
PALATE: HARD	SOFT	CHEEKS	LIPS
FRENUM	TONGUE	RIDGES	
PRESENCE OF EXUDATE		SALIVA	
AREAS OF FOOD RETENTION			
CALCULUS: SLIGHT	MODERATE	EXCESSIVE	
TMJ	NECK	OCCLUSION	
RESULTS OF X-RAYS	BONE	ROOT TIPS	IMPACTION
ABSCESSES	SUPERNUMERARY		

MEDICAL HISTORY	
LAST PHYSICAL EXAMINATION	DATE OF BIRTH
PHYSICIAN'S CARE NOW?	FOR WHAT REASON?
RECEIVING ANY MEDICATION?	WHAT?
HAVE YOU EVER HAD EXCESSIVE BLEEDING FROM A CUT?	
DO YOU HAVE A MEDICAL HISTORY OF:	
RADIATION TREATMENT?	ANEMIA?
DIABETES? ARTHRITIS?	RHEUMATIC FEVER?
ABNORMAL BLOOD PRESSURE?	TB?
HEART CONDITION?	HEPATITIS?
HIV POSITIVE? OTHERS?	
DO YOU HAVE ANY ALLERGIES?	
TO PENICILLIN?	TO NOVOCAIN?

DATE	COMMENTS