DENTAL EXAMINATION FORM

PART I: TO BE COMPLETED PRIOR TO VISIT

Client Name _____

Date of Birth:
Day ☐ Month ☐ Year ☐

Examination Date:
Day ☐ Month ☐ Year ☐

Frequency Oral Hygiene is Performed:
☐ once daily ☐ twice daily ☐ three times/ day ☐ rarely/not done related to uncooperative behavior

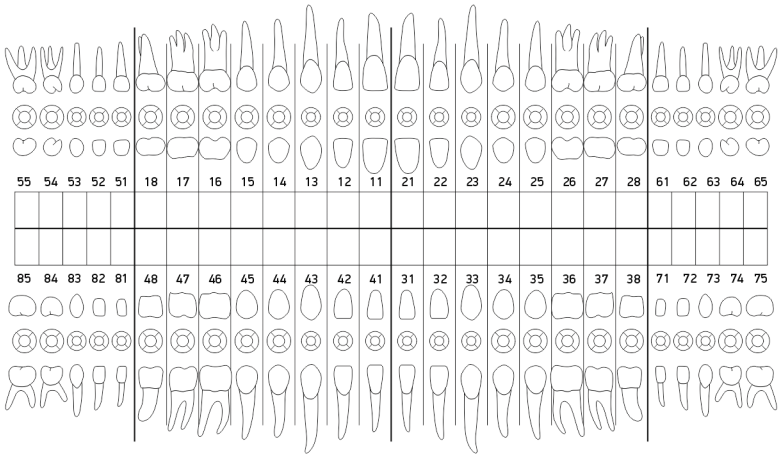
Method of Oral Hygiene:
☐ Manual toothbrush ☐ Electric toothbrush ☐ Flossing ☐ Not Flushing ☐ Oral Swabs

Gum Assessment:
☐ No bleeding associated with oral hygiene
☐ Bleeding sometimes associated with oral hygiene
☐ Bleeding always associated with oral hygiene

Signature of the Client _____
Signature of Caretaker Accompanying Client _____

PART II: TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Gingival Assessment:
maxilla _____
mandible _____
Growths _____
Occlusion _____
Ulcerations _____
Dentures:
satisfactory ☐ unsatisfactory ☐
Other _____



Tooth #	Problem	Recommendation	Intervention Performed

Services Rendered:
Cleaning/ Prophylaxis _____
X-ray _____
Other _____
Plan/ Recommendations _____
HCP Signature _____
Printed Name _____
Date/Time of Next Appointment _____

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