

DENTAL EXAMINATION FORM

DATE: _____

NAME: _____ AGE: _____ SEX: _____

ADDRESS: _____

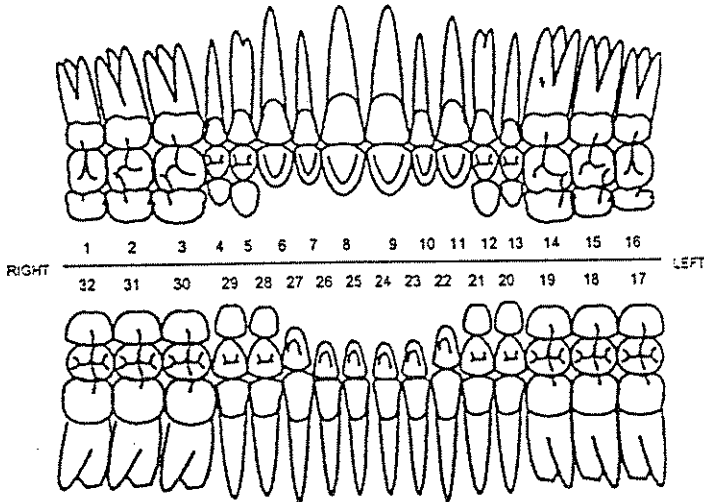
PREVIOUS EXTRACTIONS: () Local Anesthesia () General Anesthesia

() Slight Bleeding () Bleeding Normal. () Bleeding Heavy

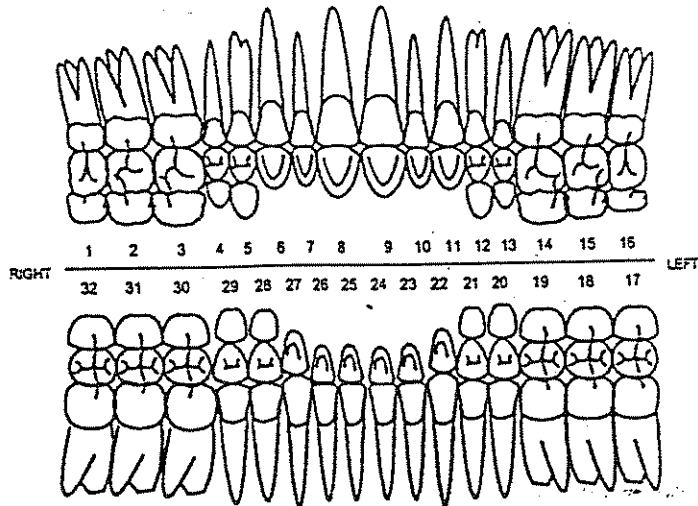
POST-OPERATIVE: Healing: () Normal () Surgical Dressings

Osteitis: _____

Treatment Performed At:



Missing Teeth and Existing Restorations, Indicated Work:



ORAL EXAMINATION:

Gingiva: Maxilla: _____

Mandible: _____

Growths: _____

Occlusion: _____

Ulcerations: _____

Other Conditions: _____

DENTURES:	Type	Satisfactory	Unsatisfactory
Maxilla			
Mandible			

Service Rendered: _____

Recommendations: _____

Dentist's Signature: _____

Name Printed: _____

Address: _____

Phone: _____