DENTAL EXAMINATION FORM

DATE: _____

NAME: _____ **AGE:** _____ **SEX:** _____

ADDRESS: _____

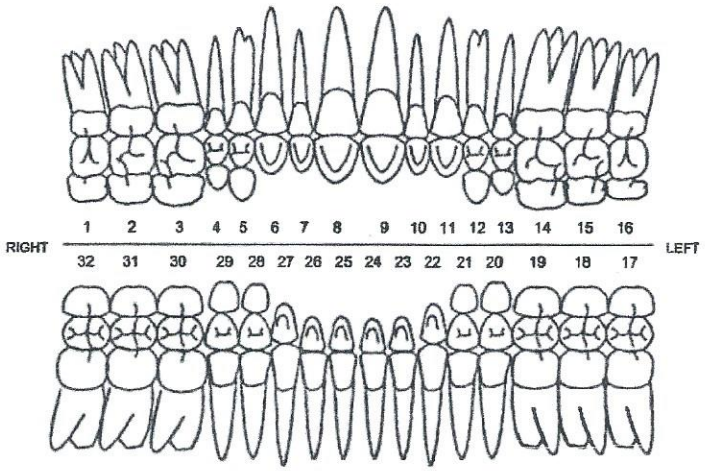
PREVIOUS EXTRACTIONS: ( ) Local Anesthesia ( ) General Anesthesia

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

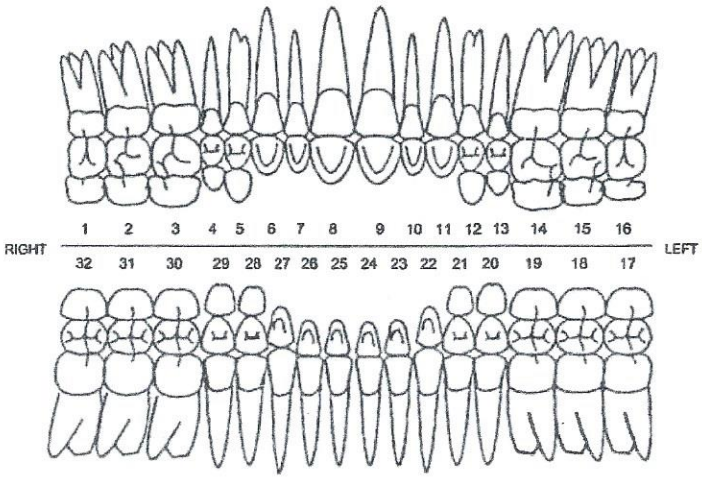
POST-OPERATIVE: Healing: ( ) Normal ( ) Surgical Dressings

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: _____