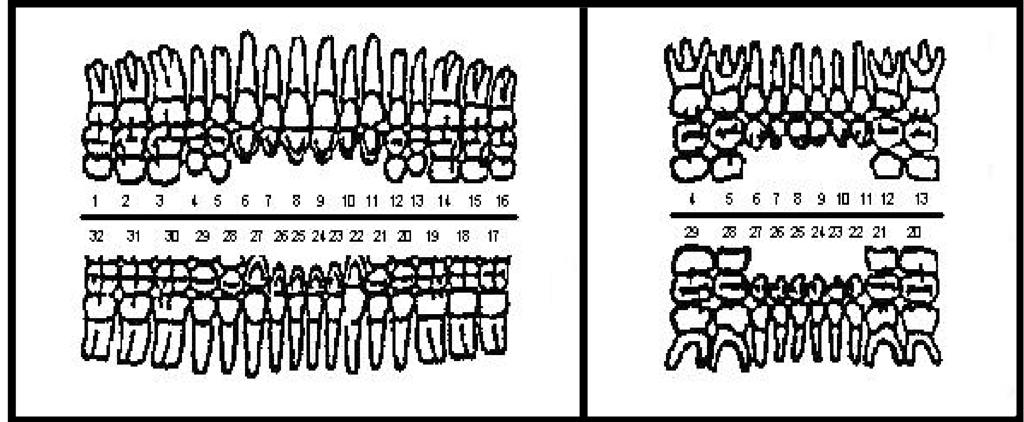
DENTAL EVALUATION *Available Funds:$__________Plan Renews:__________*

Name: ______________________________________DOB: ___________________Local Case No:_____________

Appointment Date: ____________________________Time: ___________________Reason: __________________

KEY:
X = Missing Teeth
# = Unerupted Teeth
O = Carries
1 = Extractions
SS = Stainless Steel
G = Gold Tooth



Dental Examination

DENTAL CARRIES		GUMS		OCCLUSION		TONGUE		EXAMINATION	
	None		Normal		Normal		Normal		Intra-oral
	Mild		Periodontal		Abnormal		Abnormal		Extra-oral
	Moderate		Disease		☐ Head		☐ Neck		
	Severe		Abnormal		☐ Face		☐ Cervical Lymph Nodes		

This is to verify that I have performed a complete intra-oral and extra-oral examination on this person.

Dentist Printed Name Dentist Signature

Street City State Zip Phone #

Date	Comments

Next Appt. Date: _____________________________Time: ____________________Reason:______________________________