DENTAL EXAMINATION FORM

PART I: TO BE COMPLETED PRIOR TO VISIT

Client Name: _____ **Date:** _____

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

Method of Oral Hygiene: ☐ Independent, manual toothbrush ☐ Staff assist, manual toothbrush
☐ Independent, electric toothbrush ☐ Staff assist, 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 Caretaker Accompanying Client: _____

PART II: TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Gingival Assessment: Maxilla _____
Mandible: _____

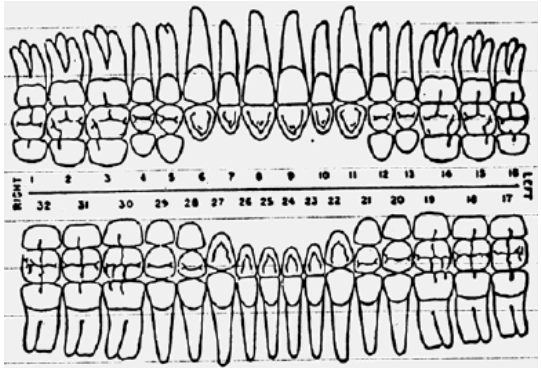
Growths: _____

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: _____