

COMPLETED TREATMENT

A B C D E																F G H I J															
RIGHT																LEFT															
17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32																															
T S R Q P																															
K																															

INITIAL X-RAY FINDINGS:

X-RAYS TAKEN: ☐ FM-PAS ☐ BWX ☐ PANO. ☐ OTHER: _____

UR	UL	LR	LL

QUADRANTS

INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMMATION: ☐ Slight ☐ Moderate ☐ Severe

SOFT PLAQUE BUILDUP: ☐ Slight ☐ Moderate ☐ Heavy

HARD CALCULUS BUILDUP: ☐ Light ☐ Moderate ☐ Heavy

STAINS: ☐ Light ☐ Moderate ☐ Heavy

HOME CARE EFFECTIVENESS: ☐ Good ☐ Fair ☐ Poor

PERIODONTAL CONDITION: ☐ Good ☐ Fair ☐ Poor

PERIODONTAL DIAGNOSIS: ☐ Normal ☐ Gingivitis ☐ Advanced

MUCOGINGIVAL DEFECTS #s: ☐ Early ☐ Moderate ☐ Advanced

CLINICAL DATA:

OCCUSION: ☐ Class I ☐ Class II ☐ Class III ☐ Crossbite: ☐ T.M.J. EXAM: ☐ Normal ☐ Popping ☐ Deviation ☐ Tooth Wear ☐ Pain

INITIAL SOFT TISSUE EXAM: ☐ Lips ☐ Floor of Mouth ☐ Palate ☐ Tongue ☐ Neck & Nodes

PATIENT'S TREATMENT DECISIONS:

☐ DOCUMENTATION OF DENTAL RECORD COMPLETED

☐ PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ALTERNATIVES DISCUSSED.)

☐ PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

NOTES

CONSENT

MAX: _____ DATE PLACED: _____ CONDITION: _____

MAND: _____ DATE PLACED: _____ CONDITION: _____

REFERRALS: _____

PERIO: _____ ORTHO: _____ ENDO: _____ OTHER: _____

ORAL SURG: _____ MD: _____ OTHER: _____

SHADE _____

Teeth _____ Upper _____ Lower _____

Cusps _____

Posts _____

SEXTANT SCORE _____

PERIODONTAL SCREENING & RECORDING _____

MONTH _____ DAY _____ YEAR _____

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) _____

Date: _____

DENTIST Signature _____

PERIODIC EXAMINATION HEALTH HISTORY UPDATE

With Changes: _____

Current Signature: _____

ALL: ☐ No ☐ Lt. ☐ Mod. ☐ Hyv.

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culus: ☐ No ☐ Lt. ☐ Mod. ☐ Hyv.

in: ☐ No ☐ Lt. ☐ Mod. ☐ Hyv.

od Pressure: ☐ No ☐ Lt. ☐ Mod. ☐ Hyv.

CANCER EXAM: ☐ Normal ☐ Lesion

TMJ: ☐ Asymptomatic ☐ Symptoms

HOMECARE: BRUSH: G F P FLOSS: G F P

PERIO DIAG: ☐ Normal ☐ Gingivitis ☐ Early Perio ☐ Mod. Perio ☐ Adv. Perio

INSTRUCTIONS: ☐ Brush ☐ Floss ☐ Perio Aid ☐ Other:

Prophylaxis: ☐ Fluoride Tr. ☐ Perio Pro. ☐ Check Next Appt.

Dr. _____ Hyg/Asst: _____

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PERIODONTAL SCREENING & RECORDING

SEXTANT SCORE

M D Y

RECORD OF SERVICES

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RECORD OF SERVICES

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RECORD OF SERVICES

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