EXAMINATION - TREATMENT - PLAN RECORD

DENTAL HISTORY:

Purpose of initial visit _____

_____

Are you aware of a problem? _____

_____

_____

How long since your last dental visit? _____

What was done at that time? _____

_____

Previous Dentist _____

Have you made regular visits? _____

Were dental x-rays recently taken? _____

Have you lost any teeth? _____ Why? _____

Were there any complications after tooth removal? _____

_____

_____

Have they been replaced? _____ When? _____

How? _____

_____

Do you clench or grind your teeth? _____

Does your jaw click or pop? _____

Have you experienced any pain or soreness in the muscles of your face or around the ear? _____

Does food get caught between your teeth? _____

Are any teeth sensitive to hot _____ cold _____

sweets _____ pressure _____

How often do you brush your teeth? _____ When? _____

Do your gums bleed or hurt when brushing? _____

Do you use dental floss? _____

How often? _____

Has anybody told you your breath is offensive? _____

How do you feel about your teeth in general? _____

_____

Are you happy with the appearance of your teeth? _____

Do you wish you had whiter teeth?..... ❑YES ❑NO

Have you had any unpleasant dental experiences or anything about dentistry that you strongly disliked? _____

_____

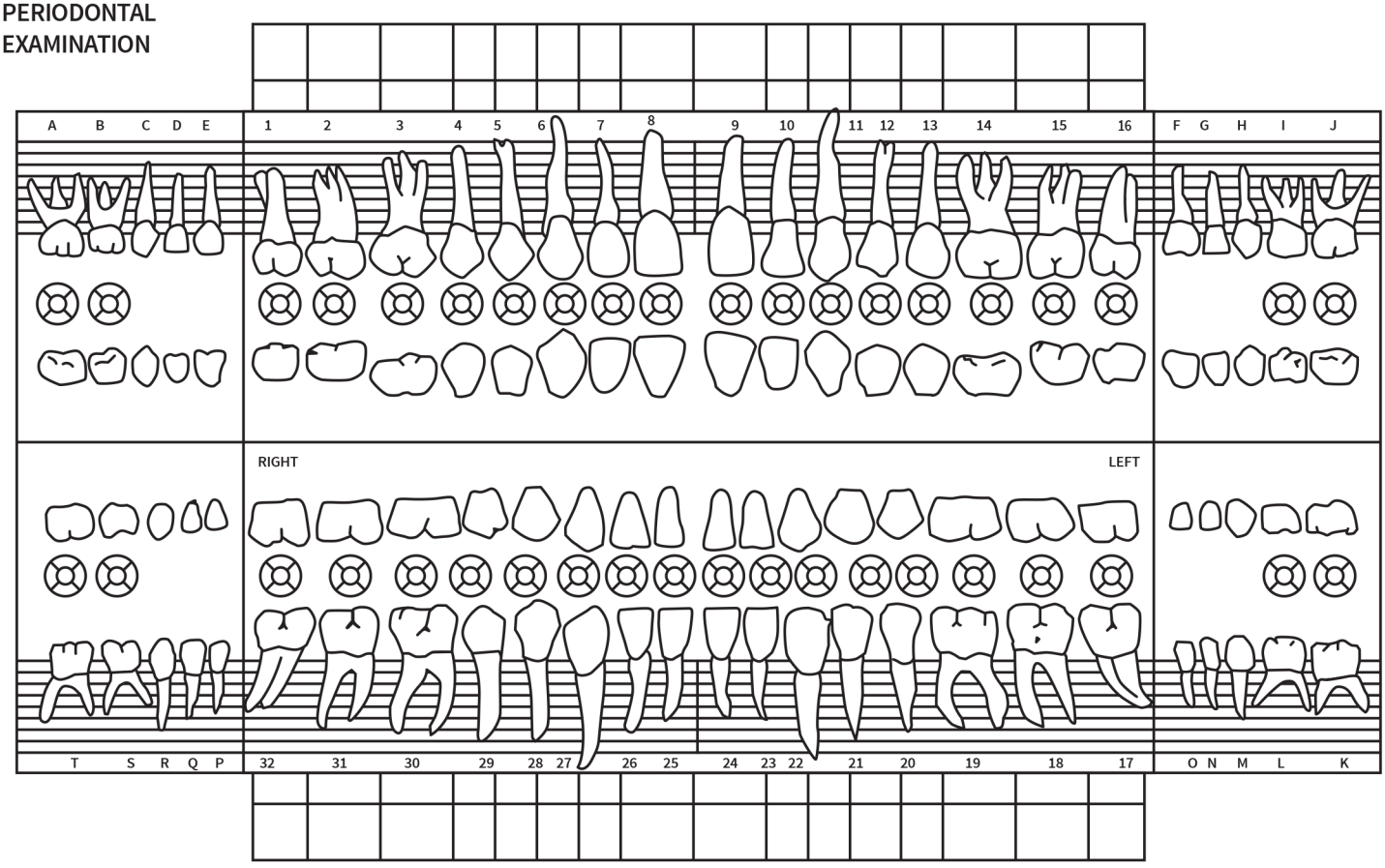
Do you have any questions or concerns? _____

_____

RADIOGRAPHS REQUIRED (Enter on radiographic log after taking)

BW _____ PAN _____ FMX _____ PA _____ Other _____

CLINICAL EXAMINATION

5.1 ORAL, SOFT TISSUE AND TMJ EXAMINATION

PERIODONTAL EXAMINATION