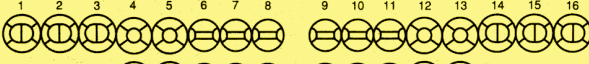
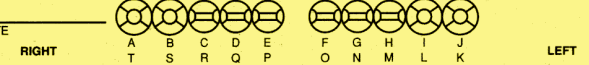


PATIENT NUMBER

PATIENT'S NAME _____ DATE _____ DATE OF BIRTH _____
 NICKNAME _____ AGE _____ HYGIENIST _____ DOCTOR _____

RESTORATION NEEDS

B 

L 

OCCCLUSION

Molar R _____ Molar L _____ O-Bite _____ mm %
 Cuspid R _____ Cuspid L _____ O-Jet _____ mm
 Midline _____ / _____ Tongue Thrust Y N
 Crossbite _____ / _____
 Orthodontic Referral _____

TMJ EVALUATION

Max. Opening _____ mm Deviation on opening? _____

REGIONAL EXAM		EXISTING X-RAYS	Date
Head	WNL	BW	
Neck	WNL	PA	
Skin	WNL	FMX PAN	
SOFT TISSUE		Other	
Lips	AB WNL	COOPERATION	
Frenum	AB WNL	Good	Average
Palate	AB WNL	HYGIENE INSTRUCTIONS	
Tongue	AB WNL	T	
Cheeks	AB WNL	Floss	
Ankyloglossia	Y N	Hygiene aids	
Gingiva	AB WNL	FL	

NO.	PROBLEM

Treatment Schedule

Comments: _____


IS THERE ANY CHANGE IN MEDICAL HISTORY OR MEDICATION YES NO


CONDITION	MEDICATION	DOSAGE	DATE

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.
 PARENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DATE _____ HYGIENIST _____ DOCTOR _____

RESTORATION NEEDS

B 

L 

OCCCLUSION

Molar R _____ Molar L _____ O-Bite _____ mm
 Cuspid R _____ Cuspid L _____ O-Jet _____ mm
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I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.
 PARENT'S / GUARDIAN'S SIGNATURE _____ DATE _____