

PATIENT NUMBER

PATIENT'S NAME _____ Last First Initial Date of Birth _____

CHARTING CODES/SYMBOLS
Note: Only record significant changes from last Perio Exam Record.

PROBING DEPTH: mm
RECESSION: mm
NO ATTACHED GINGIVA = No A.G.
FURCATIONS:

MOBILITY: I (SLT) II (MOD) III (ADV)
DEFECTIVE RESTORATION = DR
SUPPURATION = S
DECAY = D

PLAQUE	SLIGHT <25%	MODERATE 25-50%	EXCESSIVE >50%
BLEEDING	SLIGHT <25%	MODERATE 25-50%	EXCESSIVE >50%

Date: / /		DA:	DH:	DR:	SPECIAL INSTRUCTIONS:		X-RAYS: Date/Type _____																
OT/LATE					MED HX: CHG / NO		DENT HX: CHG / NO																
					APPLIANCE _____		DAY/NITE _____ X/WK																
DEX	TYPE	X/DAY	X/WK	DEMO	DISP	H + N EXAM: POS / NEG	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
A	TB					APPOINTMENT STATUS	F																
B	FL					Maintenance Visit (Alt): _____ Mos.	L																
C	IPBR					Maintenance Visit (Here): _____ Mos.	F	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
D	Btl. SML					Time Required _____	L																
MOTIV	Tuft					TREATMENT	PLAQUE	Facial	Interprox	Lingual	BLEEDING	Facial	Interprox	Lingual									
A	Stimudent					<input type="checkbox"/> Periodontal Evaluation	UR (Quad)				UR (Quad)												
B	Disc. Soin.					<input type="checkbox"/> Decay & Restoration Check	UL				UL												
C						<input type="checkbox"/> Scaling & Perio Root Planing	LR				LR												
D						<input type="checkbox"/> Coronal Polishing	LL				LL												
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B	Disc. Soin.					<input type="checkbox"/> Decay & Restoration Check	UL				UL												
C						<input type="checkbox"/> Scaling & Perio Root Planing	LR				LR												
D						<input type="checkbox"/> Coronal Polishing	LL				LL												
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