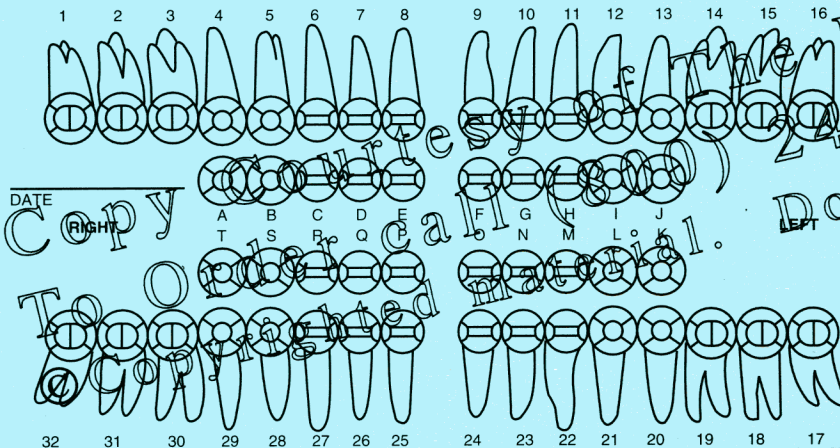


PATIENT NUMBER

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

MISSING TEETH & EXISTING RESTORATIONS



PATIENT'S CHIEF COMPLAINT:

Dental Record 243-4675 Not Duplicate.

EXISTING X-RAYS Dates

- BW
- PA
- FMX
- PAN
- Other

SEALANTS PRESENT Condition

Plaque	Calculus	Bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REGIONAL EXAM

Head WNL
 Neck WNL
 Skin WNL

OCCUSION

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

SOFT TISSUE

Lips AB WNL
 Frenum AB WNL
 Palate AB WNL
 Tongue AB WNL
 Cheeks AB WNL
 Ankyloglossia Y N
 Gingiva AB WNL

Facial Asymmetry Y N Excessive Vertical Dimension Y N
 Crossbite _____ / _____ Bruxism Clenching
 Space Loss / Arch Length _____
 Supernumerary Teeth _____
 Congenitally Missing Permanent Teeth _____
 Anterior Crowding: Maxillary? Y N Mandibular? Y N
 Permanent Root Resorption? Y N
 Orthodontic Referral?

TMJ EVALUATION

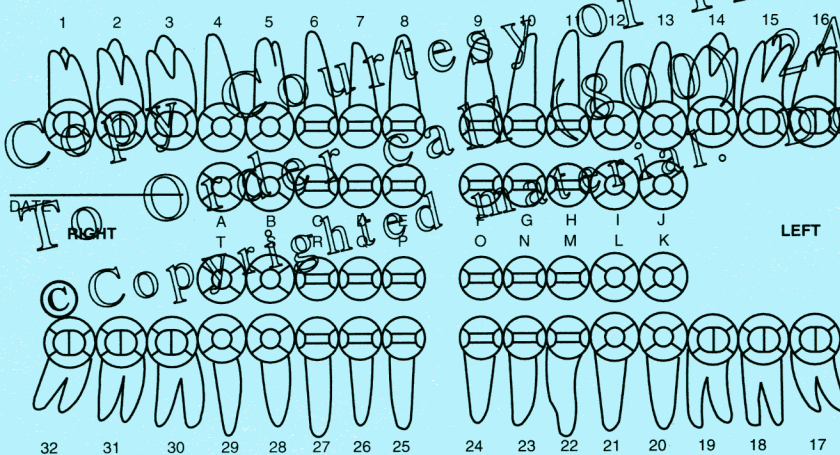
Max. Opening _____ mm Deviation on Opening?

COMMENTS:

COOPERATION: Good Average Poor

COMMENTS:

CONDITIONS / TREATMENTS INDICATED



NO.	PROBLEMS

Treatment Schedule

SIGNATURE OF DENTIST

ANEST.

MED. ALERT

(Age 3 and over)