

Last Name _____ First Name _____
 Address _____

Phone# _____ DOB _____

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

Medical alerts _____

MOULD

TEETH	Upper
Centrals	
Laterals	
Cuspid	
Posteriors	

SHADE

TEETH	Upper
Centrals	
Laterals	
Cuspid	
Posteriors	

DENTAL HISTORY

Chief Complaint _____

Date of last Visit _____

X-Rays _____ Prophyl _____

Face/Neck/Glands _____

Lips/Cheeks _____

Palate/Pharynx _____

Floor of mouth/Tongue/Frenum _____

General Condition of Teeth _____

Esthetics _____

Sensitivity Cold Hot S _____

Abrasion Areas _____

General Condition of Restorations _____

Overhangs _____

Open Contacts _____

Food Traps _____

Occlusion/Interferences _____

Previous Orthodontics _____

General Periodontal Health _____

Previous Periodontal Treatment _____

Plaque 1

Inflammation 1

Calculus 1

Stain 1

Oral Hygiene 1

Summary of treatment _____

Dental Exam Form

Remarks _____

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S Baum



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