

# COMPLETED TREATMENT

A B C D E					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	F G H I J																																											
T S R Q P					RIGHT								LEFT								O N M L K																																											
32					31				30				29				28				27				26				25				24				23				22				21				20				19				18				17			

## INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMMATION:  Slight  Moderate  Severe  
 SOFT PLAQUE BUILDUP:  Slight  Moderate  Heavy  
 HARD CALCULUS BUILDUP:  Light  Moderate  Heavy  
 STAINS:  Light  Moderate  Heavy  
 HOME CARE EFFECTIVENESS:  Good  Fair  Poor  
 PERIODONTAL CONDITION:  Good  Fair  Poor  
 PERIODONTAL DIAGNOSIS:  Normal  Gingivitis  
 PERIODONTITIS:  Early  Moderate  Advanced  
 MUCOGINGIVAL DEFECTS #s: \_\_\_\_\_

## INITIAL X-RAY FINDINGS:

X-RAYS TAKEN:  FM-PAS  BWX  PANO.  OTHER: \_\_\_\_\_  
 NO BONE LOSS  
 SLIGHT BONE LOSS (04600)  
 MODERATE BONE LOSS (04700)  
 MAJOR BONE LOSS (04800)  
 BEGINNING FURCATION (04700)  
 ADVANCED FURCATION (04800)  
 OTHER: \_\_\_\_\_

	QUADRANTS			
	UR	UL	LR	LL

## CLINICAL DATA:

OCCLUSION:  Class I  Class II  Class III  Crossbite: \_\_\_\_\_  
 T.M.J. EXAM:  Normal  Popping  Deviation  Tooth Wear  Pain

## INITIAL SOFT TISSUE EXAM:

Lips  Floor of Mouth  Palate  Tongue  Neck & Nodes

## PATIENT'S TREATMENT DECISIONS:

DOCUMENTATION OF DENTAL RECORD COMPLETED  
 PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ALTERNATIVES DISCUSSED.)  
 PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

## SHADE

Teeth	Upper	Lower
Cents		
Lats		
Cusp		
Posts		

## PERIODONTAL SCREENING & RECORDING


SEXTANT SCORE: \_\_\_\_\_ MONTH: \_\_\_\_\_ DAY: \_\_\_\_\_ YEAR: \_\_\_\_\_

## EXISTING PROSTHESIS:

MAX: \_\_\_\_\_ DATE PLACED: \_\_\_\_\_ CONDITION: \_\_\_\_\_  
 MAND: \_\_\_\_\_ DATE PLACED: \_\_\_\_\_ CONDITION: \_\_\_\_\_

## REFERRALS:

PERIO: \_\_\_\_\_ ORTHO: \_\_\_\_\_ ENDO: \_\_\_\_\_  
 ORAL SURG: \_\_\_\_\_ MD: \_\_\_\_\_ OTHER: \_\_\_\_\_

# NOTES

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# CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) \_\_\_\_\_ Date: \_\_\_\_\_ DENTIST Signature \_\_\_\_\_