Dental Examination Form

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Contact number: _____ Date of exam: _____ dd / mm / yyyy

Address:

MEDICAL HISTORY

Existing medical conditions:

Current medications:

Allergies:

DENTAL HISTORY

Date of last dental exam: _____ dd / mm / yyyy Last X-rays taken: _____

Any dental concerns or pain:

EXAMINATION FINDINGS

Teeth examination

Cavities detected:

◯ Yes ◯ No

Number of cavities: _____

Condition of existing fillings:

Gums and soft tissue

Signs of inflammation:

◯ Yes ◯ No

Bleeding on probing:

◯ Yes ◯ No

Gum pocket depths:

Occlusion and jaw

Signs of grinding or clenching:

◯ Yes ◯ No

TMJ condition:

X-RAYS

X-rays taken:

◯ Yes ◯ No

Findings:

DENTIST'S NOTES

Specify below:

Dentist's name: _____

Signature: