

HEALTH RECORD	DENTAL
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SECTION I, DENTAL EXAMINATION

1. PURPOSE OF EXAMINATION					2. TYPE OF EXAM				3. DENTAL CLASSIFICATION				
INITIAL	SEPARATION	OTHER (Specify)			1	2	3	4	1	2	3	4	5

4. MISSING TEETH AND EXISTING RESTORATION

MISSING TEETH AND EXISTING RESTORATION

REMARKS

PLACE OF EXAMINATION _____ DATE _____

SIGNATURE OF DENTIST COMPLETING THIS SECTION _____

5. DISEASES, ABNORMALITIES, AND X-RAYS

A. CALCULUS

<input type="checkbox"/> SLIGHT	<input type="checkbox"/> MODERATE	<input type="checkbox"/> HEAVY
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B. PERIODONTOCLASIA

<input type="checkbox"/> LOCAL	<input type="checkbox"/> GENERAL	
<input type="checkbox"/> INCIPIENT	<input type="checkbox"/> MODERATE	<input type="checkbox"/> SEVERE

C. STOMATITIS (Specify)

<input type="checkbox"/> GINGIVITIS	<input type="checkbox"/> VINCENT'S
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D. DENTURES NEEDED
(Include dentures needed after indicated extractions)

FULL		PARTIAL	
U	L	U	L

ABNORMALITIES OF OCCLUSION - REMARKS

E. INDICATE X-RAYS USED IN THIS EXAMINATION

<input type="checkbox"/> FULL MOUTH PERIAPICAL	<input type="checkbox"/> POSTERIOR BITE-WINGS	<input type="checkbox"/> OTHER (Specify)
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DATE _____ PLACE OF EXAMINATION _____ SIGNATURE OF DENTIST COMPLETING THIS SECTION _____

SECTION II. PATIENT DATA

6. SEX	7. RACE	8. GRADE, RATING, OR POSITION	9. ORGANIZATION UNIT	10. COMPONENT OR BRANCH	11. SERVICE DEPT., OR AGENCY
12. PATIENT'S LAST NAME - FIRST NAME - MIDDLE NAME				13. DATE OF BIRTH (DAY-MONTH-YEAR)	14. IDENTIFICATION NUMBER

