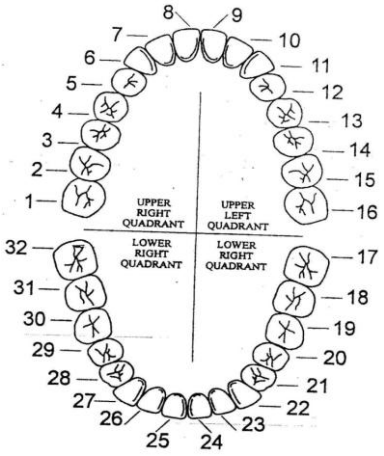
Dental Exam Form

Client Name _____ Date of Visit:_____
DDS Name_____
Reason for Visit/Chief Complaint:_____
_____
_____
Staff completing forms _____Staff Accompanying _____
Provider to complete upper section, attach Health Record Form and Current MAR and bring to the appointment

Exam Results for DDS to complete:



1. Does consumer have all of his natural teeth? _____YES _____NO
   If "No" – Mark on diagram those missing with an "X".
2. Do any teeth have visible evidence of decay? _____YES _____NO
   If "Yes" – list #'s _____
3. Are any teeth broken? _____YES _____NO
   If "Yes" – list #'s _____
4. Are any teeth loose? _____YES _____NO
   If "Yes" – list #'s _____
5. Does consumer have a prosthesis? _____YES _____NO
   If "Yes" – list #'s _____
6. Does consumer have dentures? _____YES _____NO
   If "Yes" _____Upper _____Lower _____Both
7. Are gums overgrown at base of teeth? _____YES _____NO
8. Is there any visible evidence of white spots, black spots or ulcerations?
   On the cheeks _____YES _____NO
   On the roof _____YES _____NO
   On/Under the tongue _____YES _____NO
   If "Yes" – list & describe: _____
9. Is oral mucosa shiny and pink? _____YES _____NO
10. Does consumer complain of pain or discomfort?
    In mouth _____YES _____NO
    With teeth _____YES _____NO
    With Dentures _____YES _____NO
    If "Yes" – list & describe: _____
11. Is consumer capable of:
    Brushing natural teeth _____YES _____NO
    Brushing/cleaning dentures _____YES _____NO
    Flossing _____YES _____NO

Recommendations/New Orders:

_____ _____
Dentist's Signature Date

FOLLOW UP APPOINTMENT DATE/TIME: _____
Name of Nurse/Supervisor Notified of Above: _____ Date/Time Notified: _____
Staff Notifying: _____ Medications Received Date/Time/Initials _____
Order Transcribed and checked by 2 staff -- Date/Time/Initials _____ _____
Outreach Services of Indiana/adapted from Carey Services Dental Exam Form