

DENTAL EXAM

BUMED Approved EZ603.2 (trial)

S: Reason for Examination: Initial / Periodic / Separation / SF88 / Other

Chief Complaint: None/

Use INK!

O: Type of Exam: T-1 T-2 Blood Pressure: / HQ dated: Reviewed

HQR: WNL/

Radiographs Ordered: BWs Pano PA#

Findings: (except caries)

Caries, defective restorations & fractured teeth. (radiographic & clinical) None / Noted as follows:

Incip:

OCS/Soft Tissue: WNL/

Endo: WNL/

Max

Mand

	R	PSR	L
Max			
Mand			

TMD: WNL/ Pain/ Dysfunction

Occlusion: WNL/

Oral Surgery: WNL/Impacted:#

Partial Impacted (Comm):#

Symptomatic:#

Other findings:

A: Assessment of Chief Complaint:

Perio: Healthy / Gvitis (Local/Gen) / Pdtis (Mild/Mod/Severe) / Other

Oral Surgery :

Endo:

Tobacco use: None/

Other:

RISK ASSESSMENT		
Caries	Perio	Cancer
High	High	High
Mod	Mod	Mod
Low	Low	Low

P: Treatment Plan

Department	TREATMENT NEEDS				DATA ENTRY	
	Sequence	Urgent	Sequence	Routine	Urgent	Routine
HYGIENE		RDH(1) DT(2) DO(3)		RDH(1) DT(2) DO(3)	1 2 3 1 2 3	1 2 3 1 2 3
OPER Regular (Teeth) Priority (*) High Priority					1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4
					5 6 7 8 5 6 7 8	5 6 7 8 5 6 7 8
					1 2 3 4	
					5 6 7 8	
ORAL SURG Simple (Teeth) Complex		1 16 17 32		1 16 17 32	1 2 3 1 2 3	1 2 3 1 2 3
		1 16 17 32		1 16 17 32	4 5 6 4 5 6	4 5 6 4 5 6
PERIO Eval Non-surg (Quad) Surg					1 1	1 1
		1 2 3 4		1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4
		1 2 3 4		1 2 3 4	1 2 3 4 1 2 3 4	1 2 3 4 1 2 3 4
ENDO Ant. (Teeth) Post.					1 2 3 1 2 3	1 2 3 1 2 3
					1 2 3 1 2 3	1 2 3 1 2 3
PROS Fixed (Teeth) Rem. (Units)					1 2 3 1 2 3	1 2 3 1 2 3
					4 5 6 4 5 6	4 5 6 4 5 6
ORAL DIAG					1 2 1 2	1 2 1 2
SEALANTS (Teeth)					1 1	1 1
					1 2 3 1 2 3	1 2 3 1 2 3
					4 5 6 4 5 6	4 5 6 4 5 6

ADDITIONAL REMARKS (See reverse)

Patient counseled regarding the health hazards associated with tobacco use and where to seek cessation assistance.

Patient has been advised of the findings of this examination and treatment plan.

Examiner's Signature

Date:

Name Stamp:

Treatment completed and T2 exam performed this date:

Examiner's Signature

Date:

Name Stamp:

RECALL DATE

RECALL INTERVAL

12 Months

DENTAL CLASS

1 2 3 4

Patient's Last Name:

First Name:

MI:

FMP / SSN: