

# Initial Exam and Treatment Plan

**Patient Name:** \_\_\_\_\_

**Doctor:** \_\_\_\_\_

Existing Removables/Age: FUD / \_\_\_\_ FLD / \_\_\_\_ PUD / \_\_\_\_ PLD / \_\_\_\_

Date: \_\_\_\_\_

Patient Concerns: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_

Tooth #	Existing Condition Surface / Restoration	Age	New Pathology Surface / Pathology	Ideal Treatment			Optional Treatment			Priority 1,2,3	Time Units at next Appt	✓
				A	C	BU	A	C	BU			
1												
2												
3												
4 A												
5 B												
6 C												
7 D												
8 E												
9 F												
10 G												
11 H												
12 I												
13 J												
14												
15												
16												
17												
18												
19												
20 K												
21 L												
22 M												
23 N												
24 O												
25 P												
26 Q												
27 R												
28 S												
29 T												
30												
31												
32												

- Periodontal Treatment Rx: AP ProFl IT SRP: UR UL LR LL UA LA \_\_\_\_\_Gross \_\_\_\_\_Fine
- Proposed Removables: FUD FLD PUD PLD Relines: Soft \_\_\_\_\_ Lab \_\_\_\_\_
- Occlusal Guard: Hard Soft \_\_\_\_\_ Anesthesia: \_\_\_\_\_ Med. Alert: \_\_\_\_\_
- Whitening Shade \_\_\_\_\_ Referrals: \_\_\_\_\_
- Mock-up: Tooth #s \_\_\_\_\_
- Smile Design: Tooth #s \_\_\_\_\_

# Comprehensive Oral Evaluation

**Patient Name:** \_\_\_\_\_

**Doctor:** \_\_\_\_\_

BP \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Pulse \_\_\_\_\_/min. Resp \_\_\_\_\_/min.

Date: \_\_\_\_\_

Head and Neck:	WNL	Comments	Soft Tissues	WNL	Comments
Face	<input type="checkbox"/>	_____	Lips	<input type="checkbox"/>	_____
Sinuses	<input type="checkbox"/>	_____	H/S palates	<input type="checkbox"/>	_____
Muscles / mastication	<input type="checkbox"/>	_____	B/V mucosa	<input type="checkbox"/>	_____
Preauric / Postauric	<input type="checkbox"/>	_____	Parotid gland	<input type="checkbox"/>	_____
Submen / Submand	<input type="checkbox"/>	_____	Floor of mouth	<input type="checkbox"/>	_____
SCM - superficial	<input type="checkbox"/>	_____	Tongue	<input type="checkbox"/>	_____
SCM - deep	<input type="checkbox"/>	_____	Tobacco user?	No	Yes
Trap - superficial	<input type="checkbox"/>	_____	Additional Comments: _____		
Trap - deep	<input type="checkbox"/>	_____			
Occipital - superficial	<input type="checkbox"/>	_____			
Neck region	<input type="checkbox"/>	_____			

TMJ Evaluation:	WNL	Comments?	Symptoms?
Right ___ Crepitus	<input type="checkbox"/>	_____	_____
Left ___ Crepitus	<input type="checkbox"/>	_____	_____
Muscles: _____	<input type="checkbox"/>	_____	_____
Maximum Opening: _____ mm	<input type="checkbox"/>	_____	_____
Sideshift R _____ mm	<input type="checkbox"/>	_____	_____
L _____ mm	<input type="checkbox"/>	_____	_____

Occlusal Evaluation:	Molar Class:
Centric Relation	_____ R _____ L
Right Lateral	Cuspid Class: _____ R _____ L
Overjet: _____ mm	_____ mm
Overbite: _____ %	_____ %
Habits: Bruxism	Clenching
Tongue	Mouthbreathing
Protrusive	Fremitus: _____

Gingival Assessment:	WNL
Color: _____	<input type="checkbox"/> Gen. Slight Moderate Severe Redness _____
Consistency: _____	Isol. Slight Moderate Severe Redness _____
Bleeding upon probing?: No	<input type="checkbox"/> Edematous Soft Spongy Boggy Hyperplastic
Yes: Gen. Slight Moderate Severe Redness _____	

Deposits Present:	None Slight Moderate Heavy
Plaque:	_____
Supracalculus:	_____
Subcalculus:	_____
Stain:	_____

**Preliminary Periodontal Classification:** Pedo 0 I II III IV V

**Periodontal Spot Probing / PSR:**

R	L

**Notes:**

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