DENTAL EXAMINATION FORM

PART I: TO BE COMPLETED PRIOR TO VISIT

Client Name: ___________________________________________ Date: ________________________________

Frequency Oral Hygiene is Performed: _____ once daily _____ twice daily _____ three times/day
_____ Rarely/Not done related to uncooperative behavior

Method of Oral Hygiene: ______ Independent, manual toothbrush ______ Staff assist, manual toothbrush
______ Independent, electric toothbrush ______ Staff assist, electric toothbrush
______ Flossing ______ Not Flushing ______ Oral Swabs

Gum Assessment: ________ No bleeding associated with oral hygiene
_____ Bleeding sometimes associated with oral hygiene
_____ Bleeding always associated with oral hygiene

Signature of Caretaker Accompanying Client: ___________________________________________________________

PART II: TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>Problem</th>
<th>Recommendation</th>
<th>Intervention Performed</th>
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Gingival Assessment: Maxilla __________________________ Mandible: __________________________

Growth:

Occlusion:

Ulceration:

Dentures: ______ Satisfactory ______ Unsatisfactory

Other: _________________________________________________

Services Rendered: _____ Cleaning/ Prophylaxis _____ X-ray _____ Other: __________________________

Plan/ Recommendations: ________________________________________________________________

HCP Signature: _______________________________________________________________________

Printed Name: _______________________________________________________________________

Date/Time of Next Appointment: ___________________________________________________________________