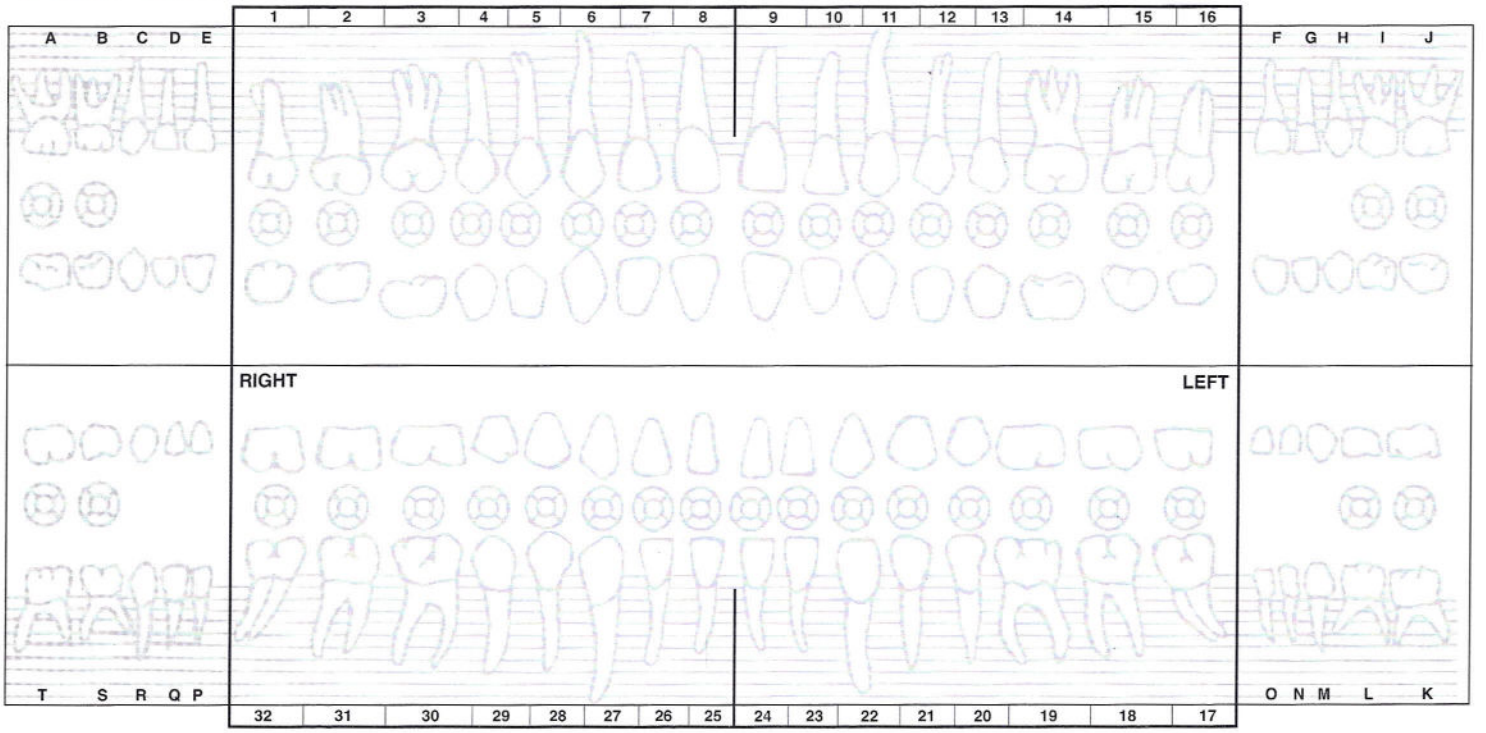
COMPLETED TREATMENT



INITIAL PERIODONTAL EXAM:

GINGIVAL INFLAMMATION:	☐ Slight	☐ Moderate	☐ Severe
SOFT PLAQUE BUILDUP:	☐ Slight	☐ Moderate	☐ Heavy
HARD CALCULUS BUILDUP:	☐ Light	☐ Moderate	☐ Heavy
STAINS:	☐ Light	☐ Moderate	☐ Heavy
HOME CARE EFFECTIVENESS:	☐ Good	☐ Fair	☐ Poor
PERIODONTAL CONDITION:	☐ Good	☐ Fair	☐ Poor
PERIODONTAL DIAGNOSIS:	☐ Normal	☐ Gingivitis	
PERIODONTITIS:	☐ Early	☐ Moderate	☐ Advanced

MUCOGINGIVAL DEFECTS #s: _____

CLINICAL DATA:

OCCLUSION: ☐ Class I ☐ Class II ☐ Class III ☐ Crossbite: _____

T.M.J. EXAM: ☐ Normal ☐ Popping ☐ Deviation ☐ Tooth Wear ☐ Pain

INITIAL SOFT TISSUE EXAM:

☐ Lips ☐ Floor of Mouth ☐ Palate ☐ Tongue ☐ Neck & Nodes

PATIENT'S TREATMENT DECISIONS:

☐ DOCUMENTATION OF DENTAL RECORD COMPLETED

☐ PATIENT INFORMED OF TX. RECOMMENDATIONS AND CONSENTS TO TX. (ALTERNATIVES DISCUSSED.)

☐ PATIENT WANTS NO TX. OR PARTIAL TX. INFORMED OF CONSEQUENCES AND RISKS INVOLVED.

INITIAL X-RAY FINDINGS:

X-RAYS TAKEN: ☐ FM-PAS ☐ BWX ☐ PANO. ☐ OTHER _____

☐ NO BONE LOSS

☐ SLIGHT BONE LOSS (04600)

☐ MODERATE BONE LOSS (04700)

☐ MAJOR BONE LOSS (04800)

☐ BEGINNING FURCATION (04700)

☐ ADVANCED FURCATION (04800)

☐ OTHER: _____

QUADRANTS

UR	UL	LR	LL

SHADE

Teeth	Upper	Lower
Cents		
Lats		
Cusp		
Posts		

PERIODONTAL SCREENING & RECORDING

SEXTANT SCORE

MONTH DAY YEAR

EXISTING PROSTHESIS:

MAX: _____ DATE PLACED: _____ CONDITION: _____

MAND: _____ DATE PLACED: _____ CONDITION: _____

REFERRALS:

PERIO: _____ ORTHO: _____ ENDO: _____

ORAL SURG: _____ MD: _____ OTHER: _____

NOTES

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____